UCI Student Health Center

PATIENT AUTHORIZATION TO RELEASE MEDICAL OR MENTAL HEALTH INFORMATION

To submit your medical records request, please complete both pages of this form.

Mail to: **501 Student Health, Irvine, CA 92697-5200**
Fax to: **949-824-3033** or email (this signed scanned document) to**: shc-medical-records@uci.edu**

Type of disclosure: ☐ Verbal Information ☐ Copies of records

Name: _____ ID # _____

Date of Birth: _____ E-mail Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

I AUTHORIZE: (The Person or facility which has health information)	**TO RELEASE HEALTH INFORMATION TO:** (Person or facility to receive health information)
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
E-mail/Fax: _____	E-mail/Fax: _____

Please note that requests are processed within 15 days of the date they were received.

If you need your records for an appointment on a specific date, please note it here: ☐

Please specify the health information you authorize to be released:

☐ Immunizations ☐ Lab Results ☐ GYN ☐ Itemized Billing (For parental disclosure only)
☐ Medical (This may include eating disorder, drug/alcohol and mental health information by a primary care practitioner)
☐ Mental Health (These releases are reviewed by the treating psychologist / psychiatrist before disclosure. Please note that psychotherapy notes and in-patient records are subject to the Lanterman-Petris-Short Act Welf & Inst. Code §5000 et seq.)
☐ Social Services (Subject to review by Licensed Social Worker before disclosure)
☐ Drug and alcohol abuse, diagnosis or treatment information subject to federal law (42 C.F.R. §§2.34 and 2.35).
☐ HIV/AIDS test results (Health and Safety Code §120980(g)).
☐ Genetic testing information (Health and Safety Code 124980(j))
☐ Educational Records
☐ Other: _____

Type(s) of information, if not specified above (e.g. Summary, Report, Letter):

Specify date(s) of treatment, time period or condition: _____

Limitations upon disclosure: _____

The purpose of this release is:

☐ At the request of the patient/patient representative
☐ Other (state reason) _____

UCI Student Health Center

EXPIRATION OF AUTHORIZATION:
Unless otherwise revoked, this Authorization expires on _____
If no date is indicated, the Authorization **will expire 12 months** after the date of my signing this form.

FEES
NO FEE FOR MEDICAL RECORDS SENT DIRECTLY TO ANOTHER HEALTH FACILITY OR CLINIC
RECORDS FOR PERSONAL USE

_____ (initial) I understand I may be charged a per page fee for copies.

_____
Print Name

_____
Patient Signature

_____
Date

Please indicate preferred delivery of records:

- ☐ Fax
- ☐ E-mail
- ☐ Mail
- ☐ Hand carried by patient
- ☐ Secure message

NOTICE: UCI and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS: This Authorization to release health information is voluntary. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) solely to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: UCI Student Health, 501 Student Health, Irvine, CA 92697-5200 – Attn: Privacy Officer. The revocation will take effect when UCI receives it, except to the extent UCI or others have already relied on it.

You are entitled to receive a copy of this Authorization.

Print Form

For Mental Health Clinic Use Only

Request noted by MHC Provider: _____ (Initials)

MR #: _____ Intials: _____

☐ mailed ☐ faxed ☐ hand carried by pt.
☐ e-mail ☐ secure msg Date Completed: _____

For Medical Record Office Use Only

MR #: _____ Intials: _____

☐ mailed ☐ faxed ☐ hand carried by pt.
☐ e-mail ☐ secure msg Date Completed: _____