UCSC Student Health Services (SHS)
1156 High St
Santa Cruz, CA 95064

Medical Records Department
Tel: (831) 459-3063
FAX: (831) 459-3546

AUTHORIZATION FOR RELEASE OF MENTAL AND/OR MEDICAL HEALTH INFORMATION

Complete All Fields in Black Ink **Check All Applicable Boxes**

Name: _____Student ID#: _____ Date of Birth:_____

Address: _____City: _____State: ____ Zip: _____ Phone: _____

I HEREBY AUTHORIZE: ☐ **UCSC Student Health Center (SHC)** ☐ **UCSC Mental Health—Counseling & Psychological Services (CAPS) / Psychiatry**

☐ **To release or** ☐ **To exchange information to/with:**

☐ College—Academic: _____ ☐ College—Res Life:_____

☐ Slug Support Network ☐ Parent(s) ☐ Clinical Provider

☐ Other: _____

I HEREBY AUTHORIZE:
(name of person or facility which has information)

Name/facility:_____

Address:_____

Phone:_____

Fax: _____

TO RELEASE TO OR EXCHANGE WITH:
(name of person or facility to receive information)

Name/facility:_____

Address:_____

Phone:_____

Fax:_____

Type of Disclosure (check all boxes that apply):

1. ☐ **Verbal Information/Communications**
2. ☐ **Copies of Records / Written Information:**
   - ☐ Immunizations ☐ TB Test ☐ Complete Record ☐ Summary Letter (CAPS only)
   - ☐ Other-Please Specify:_____

Please specify the information you authorize to be released:

- ☐ **Medical** (This may include drug, alcohol and mental health information documented by a SHC primary care practitioner).
- ☐ **Mental health information** (Subject to the CMIA Act, Welf & Inst. Code §5000 et seq.).
- ☐ **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—Cannot be released unless checked** (Health and Safety Code § 120980 (g))
- ☐ **Other information**, if not specified above:_____
- ☐ **ALL or Specify date(s)** of treatment, time period or condition:_____

_____

- ☐ **None or Limitations upon disclosure:** _____

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Purpose of this release is:

☐ Continuity of Care
☐ At the request of the client/patient/patient representative
☐ Other (state reason): _____

NOTICE:

University of California, Santa Cruz—SHS (SHC, CAPS or Psychiatry) 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 (i.e. Academic Advisor, Residential Staff, Faculty etc.), it may no longer be protected by state or federal confidentiality laws or FERPA Guidelines.

YOUR RIGHTS:

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization *except* 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 client/patient representative, and delivered to: **UC Santa Cruz Student Health Services, Medical Records**
1156 High Street, Santa Cruz, CA 95064

The revocation will take effect when UCSC Student Health Services receives it, *except* to the extent UCSC Student Health Services or others have already relied on it. You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION: *This Authorization is good for one year from date signed*, unless otherwise specified under Expiration of Authorization. Expiration of Authorization—This Authorization expires on _____

_____ _____ _____
Print Name **Signature (Patient, Parent, Guardian)** **Student ID#**

_____ _____ _____ _____
Today's Date **Time** **Relationship to Patient (If Applicable)** **Witness (only if patient unable to sign) or interpreter**

For UC Santa Cruz SHC Medical Records Department Use Only (check applicable):

Records Request:
☐ Mailed to address on page 1 Date mailed:_____
☐ Faxed to number on page 1 Time Faxed: _____
Initials: _____ Date: _____

Request for Verbal Information Only:
☐ Note entered in PnC
Initials: _____ Date: _____

Records Released:
☐ Mailed to address on page 1 Date mailed: _____
☐ Faxed to number on page 1 Time Faxed: _____
☐ Handed to patient
☐ Left in patient pickup box
☐ Electronically
Initials: _____ Date: _____

Records Obtained from SC Health Exchange:
Initials: _____ Date: _____

Records not Released:
Reason: _____
Initials: _____ Date: _____