University of California, Santa Cruz
Student Health Services
1156 High Street, Santa Cruz, CA 95064

Counseling and Psychological Services (CAPS)
TEL: (831) 459-2628
FAX: (831) 459-5116

AUTHORIZATION FOR RELEASE OF MENTAL AND MEDICAL HEALTH INFORMATION

Name _____Student ID# _____ Date of Birth _____

Address _____City _____State ____ Zip _____ Phone_____

I HEREBY AUTHORIZE : UCSC Counseling and Psychological Services (CAPS)

1156 High Street, Santa Cruz, CA 95064 phone: 831-459-2628 fax: 831-459-5116

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

☐ College—Academic _____ ☐ College—Res Life _____
☐ Slug Support Network ☐ Parent(s) ☐ Clinical Provider, type _____
☐ Other _____

(name of person or facility)

Name or facility: _____

Address_____

Phone_____

Fax _____

Type of Disclosure (check all boxes that apply):

Verbal Information : ☐

Written Information: ☐ **Complete Record** ☐ **Summary Letter** ☐ **Attendance**

Please specify the information you authorize to be released:

☐ Mental health information (Subject to the CMIA Act, Welf & Inst. Code §5000 et seq.).
☐ Medical (This may include drug/alcohol and mental health information documented by a primary care practitioner).
☐ Drug and alcohol abuse, diagnosis or treatment information subject to federal law (42 C.F.R. §§ 2.34 and 2.35) {relates to alcohol and drug specific facility}.
☐ HIV/AIDS test results (Health and Safety Code § 120980 (g))
☐ Other information, if not specified above:_____

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

_____

Limitations upon disclosure: ☐ None or Specify:_____

_____

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Purpose of this release is:

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

NOTICE:

CAPS-UCSC 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 (ie. Academic Advisor, Residential Staff, Faculty etc), it may no longer be protected by state or federal confidentiality laws.

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:

Counseling and Psychological Services, Student Health Center East Wing 2nd Floor
or mail to: CAPS, UCSC, 1156 High Street, Santa Cruz, CA 95064

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

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event).
If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____	_____
Print Name	Signature (Patient, Parent, Guardian)
_____	_____
Date Time	Relationship to Patient (If Applicable)
_____	_____
Student ID Number	Witness (only if patient unable to sign) or interpreter

For UC Santa Cruz Student Health Service Office Use Only (check applicable):

Records Request:
☐ Mailed to address on page 1
☐ Faxed to number on page 1

Initials: _____ Date: _____

Request for Verbal Information Only:
☐ Note entered in PnC

Initials: _____ Date: _____

Records Released:
☐ Mailed to address on page 1 ☐ Faxed to number on page 1
☐ Handed to patient
☐ Left in patient pickup box

Initials: _____ Date: _____ # of pages: _____

Records not Released:
☐ Patient never picked
☐ No Release made
Reason: _____

Initials: _____ Date: _____