

UNIVERSITY OF CALIFORNIA, SAN DIEGO  
9500 Gilman Drive La Jolla, CA 92093

STUDENT HEALTH SERVICES (MC 0039) COUNSELING & PSYCHOLOGICAL SERVICES (MC 0304)  
Ph: (858)534-2139/fax 534-7545 Ph: (858) 534-3755/fax 534-2628

**AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_ Student ID: \_\_\_\_\_  
(Student's Name/Legal Representative)

**Hereby authorize** UCSD Student Health Service AND Counseling & Psychological Services to:

- Release information to:     Obtain information from:     Exchange information with:  
Name: \_\_\_\_\_  
College/Dept/Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**SPECIFIC INFORMATION TO BE RELEASED.** Check each category that applies:

- \_\_\_ Medical Care, including laboratory and x-ray results
- \_\_\_ Billing Records
- \_\_\_ Information Specific to HIV Status
- \_\_\_ Drug/Alcohol/Substance Abuse Diagnosis/Treatment
- \_\_\_ Other As Specified \_\_\_\_\_

**Mental Health Treatment:**

- \_\_\_ Dates of Treatment
- \_\_\_ Oral Communication as needed
- \_\_\_ CAPS Documentation Form
- \_\_\_ Treatment Summary
- \_\_\_ Counseling/Psychological Records
- \_\_\_ Psychiatric Medication Records

**For the following purpose(s):**

- Coordination of treatment/care
- Administrative and/or Academic Coordination
- Other \_\_\_\_\_

**NOTICE:** UCSD Student Health Services, Counseling & Psychological Services, and other health care providers and organizations 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.

I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released.) This revocation must be delivered in writing to each of the treatment providers listed above.

**THIS CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM DATE OF YOUR SIGNATURE**

\_\_\_\_\_  
(Student's Signature or Legal Representative) (Date)

\_\_\_\_\_  
(Printed Name)

If you require copies of your records from Student Health Services, please complete reverse side of this form.

**REQUEST FORM  
FOR COPIES OF MEDICAL RECORDS  
FROM UCSD STUDENT HEALTH SERVICES**

Patient Name \_\_\_\_\_

Former Name \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip

Phone \_\_\_\_\_

Home

Mobile

Work

- I request my records to be faxed to the party named on the reverse side at (fax#) \_\_\_\_\_
- I request my records to be mailed to the party named on the reverse side
- I will pick up copies of my records

**\*Fees For Copying Records at Student Health Service:**

Onsite records – First 4 pages are free; thereafter, .15 per page, plus a \$5.00 administrative fee

Offsite records – First 4 pages are free; thereafter, .15 per page, plus a \$7.50 administrative fee

**Note:** Once you submit this authorization you have (1) one business day to revoke your request. Thereafter you will be responsible for all fees incurred by your request.

Would you like a courtesy call with the total fee amount? (circle one)      Yes    No

\_\_\_\_\_  
(Student's Signature or Legal Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name if different then patient name)