

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name \_\_\_\_\_ Student ID# \_\_\_\_\_  
Former Name \_\_\_\_\_ DOB \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_(\_\_\_\_)\_\_\_\_\_

**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.

Fees: 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

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

### AUTHORIZATION

I hereby authorize the release of my health information:

From: \_\_\_\_\_

To: \_\_\_\_\_

\_\_\_\_\_ Fax (if records to be faxed) \_\_\_\_\_

### LIMITATIONS

The information to be released is limited to:

\_\_\_\_\_ ALL MEDICAL RECORDS \_\_\_\_\_ GYN records  
\_\_\_\_\_ EKG records \_\_\_\_\_ History & physical exams  
\_\_\_\_\_ Immunization records \_\_\_\_\_ Laboratory/Pathology reports  
\_\_\_\_\_ Other (specify): \_\_\_\_\_

Specify date and time period for information selected above: \_\_\_\_\_

### SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by initialing (no check marks) below:

\_\_\_\_\_ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§ 2.34 and 2.35).  
\_\_\_\_\_ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§ 5328, et. Seq.).  
\_\_\_\_\_ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §§ 120980g).  
\_\_\_\_\_ I specifically authorize the release of genetic testing information (Health and Safety Code §§ 124980j).

**PURPOSE**

- \_\_\_\_\_ Continuity of care or discharge planning
- \_\_\_\_\_ At the request of the patient/patient representative
- \_\_\_\_\_ Billing and pay of bill
- \_\_\_\_\_ Other (state reason): \_\_\_\_\_

**NOTICE**

Student Health Service 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.

**MY RIGHTS**

*I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment; 2) obtaining information in connection with eligibility or enrollment in a health plan; 3) determining an entity's obligation to pay a claim; 4) creating health information to provide to a third party. Under NO circumstances, however, am I required to authorize the release of mental health records. I understand I am entitled to receive a copy of this authorization.*

*Expiration: Unless otherwise revoked, this authorization expires \_\_\_\_\_ (insert date), or 12 months after the date of signing this form if no date is indicated.*

**SIGNATURE**

Patient (or Legal Representative) Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Time \_\_\_\_\_ a.m./p.m.

Relationship (if signed by someone other than the patient) \_\_\_\_\_

Witness (only if patient unable to sign) or Interpreter \_\_\_\_\_