



If you need your records for a particular date, please note it here: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL OR MENTAL HEALTH INFORMATION**

Name \_\_\_\_\_ Perm/ID # \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**NOTICE:** UCSB 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. 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 patient representative, and delivered to Medical Records Dept, Student Health Services, University of California, Santa Barbara, CA 93106-7002. The revocation will take effect when UCSB receives it, except to the extent UCSB or others have already relied on it. **You are entitled to receive a copy of this Authorization.**

**WE NEED YOU TO:** Complete the following form for your medical records request and submit both pages to:

**STUDENT HEALTH SERVICE**  
**Medical Records Department**  
**University of California**  
**Santa Barbara, CA 93106-7002**  
**Phone: 805-893-2488 Fax:805-893-2758**

**I AUTHORIZE:**  
**(Person or facility which has health information)**  
Name \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**TO RELEASE HEALTH INFORMATION TO:**  
**(Person or facility to receive health information)**  
Name \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Type of disclosure:  Verbal Information  Copies of records

**Please specify the health information you authorize to be released:**

- GYN  Immunizations  Lab Results  Social Services
- Medical (This may include drug/alcohol and mental health information documented by a primary care practitioner)
- Mental health information (Subject to the Lanterman-Petris-Short 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 (Health and Safety Code §120980(g)).

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 client/patient/patient representative  Other (state reason) \_\_\_\_\_

**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.

**PERSONAL USE**

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Release Received by: \_\_\_\_\_