

**Office Use Only:**

Release Received by: \_\_\_\_\_ on \_\_\_\_\_ via \_\_\_\_\_ e-mail \_\_\_\_\_ in person \_\_\_\_\_ mail  
*name date*

**PATIENT AUTHORIZATION TO RELEASE MEDICAL OR MENTAL HEALTH INFORMATION**

To submit your medical records request, please complete both pages of this form.

Mail to: **University of California, STUDENT HEALTH - Medical Records, Santa Barbara, CA 93106-7002**

Fax to: **805-893-2758** or email (this signed scanned document) to: **SHSRecordsRequest@sa.ucsb.edu**

**Type of disclosure:**       Verbal Information       Copies of records

Name \_\_\_\_\_ Perm/ID # \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ E-mail Address \_\_\_\_\_

Address \_\_\_\_\_

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

**I AUTHORIZE:**

**(The 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: \_\_\_\_\_

Please note that requests are processed within 15 days of the date they were received.

**If you need your records for an appointment on a specific date, please note it here:** \_\_\_\_\_

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

- Immunizations       Lab Results       GYN       Itemized Billing (For parental disclosure only)
- Medical (This may include eating disorder, drug/alcohol and mental health information by a primary care practitioner)
- Mental Health (These releases are reviewed by the treating psychologist / psychiatrist before disclosure. Please note that psychotherapy notes and in-patient records are subject to the Lanterman-Petris-Short Act, Welf & Inst. Code §5000 et seq.)
- Social Services (Subject to review by Licensed Social Worker before disclosure)
- 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)).
- Genetic testing information (Health and Safety Code 124980(j))

**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 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.

**FEES**

**NO FEE FOR MEDICAL RECORDS SENT DIRECTLY TO ANOTHER HEALTH FACILITY OR CLINIC RECORDS FOR PERSONAL USE**

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

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

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

\_\_\_\_\_  
Date

<b>OFFICE USE ONLY:</b>			
Date Records Released:	_____		
Number of Pages:	_____		
By:	Pickup	Fax	Mail
Charges Assessed: \$	_____		

**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. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form 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: UCSB Student Health, 588 Building, Santa Barbara, CA 93106-7002 – Attn: Privacy Officer. 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.**