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:	**TO RELEASE HEALTH INFORMATION TO:**
(The Person or facility which has health information)	**(Person or facility to receive health information)**
Name_____	Name_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Fax:_____	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

1 – 5 Documents = No Charge

6 – 25 Documents = $10

26 – 50 Documents = $15

51 – 100 Documents = $25

$5.00 Additional for every 25 Documents over 100 Documents

Rush requests (1-3 days) **additional $10**

_____ (initial) I understand I may be charged a fee for copies.

_____

Print Name

_____

Patient Signature

_____

Date

OFFICE USE ONLY:

Date Records Released: _____

Number of Documents: _____

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.