

**Authorization for Release of Medical/Billing Information**

Patient Name (Last, First): _____
Birthdate: _____ UCSF Student ID: _____
Phone: _____ Email: _____

I authorize UCSF Student Mental Health and Wellbeing to release health information to:

Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Email: _____

Type of Disclosure Request (choose one option):☐ Verbal Communication (e.g. family member)☐ Paper Records☐ Pick Up in Person☐ Mail**Please specify the health information you authorize to release:**

	All Dates	OR	Limited Dates
☐ Immunization Records Only	☐		___/___/___ to ___/___/___
☐ Laboratory Results Only	☐		___/___/___ to ___/___/___
☐ X-ray Reports Only	☐		___/___/___ to ___/___/___
☐ Optometry Records Only	☐		___/___/___ to ___/___/___
☐ All Medical Records (<i>This may include eating disorder, drug/alcohol and mental health information by a primary care practitioner.</i>)	☐		___/___/___ to ___/___/___
☐ Itemized Billing Statements (incl. CPT codes)	☐		___/___/___ to ___/___/___
☐ Statement of Medication Dispensed	☐		___/___/___ to ___/___/___
☐ Other: _____	☐		___/___/___ to ___/___/___
Sensitive information will not be released unless specifically authorized below:			
☐ HIV/AIDS Test Results	☐		___/___/___ to ___/___/___
☐ Drug/Alcohol Treatment Information	☐		___/___/___ to ___/___/___
☐ Genetic Testing Information	☐		___/___/___ to ___/___/___
☐ Mental health records (Subject to the Lanterman-Petris-Short Act, Welf & Inst. Code §5000 et seq.) documented by SMHW psychologists and psychiatrists	☐		___/___/___ to ___/___/___

Limitations upon disclosure: _____

The purpose of this release is: ☐ At the request of the patient ☐ Other (specify): _____

You are entitled to receive a copy of this Authorization. Unless otherwise specified, this Authorization is valid for 12 months after the date of signing this form. After 12 months, the record copies will be destroyed.

Client/Patient/Patient Representative Signature

Relationship to Client/Patient (if other than Client/Patient)

Date

NOTICE: UCSF SMHW 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 obtain information in connection with eligibility or enrollment in a health plan, (2) to determine an entity's obligation to pay a claim, or (3) 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 via secure message to the admin remote mailbox. The revocation will take effect when UCSF SMHW receives it, except to the extent UCSF SMHW or others have already relied on it. You are entitled to receive a copy of this Authorization.