

## STUDENT HEALTH AND WELL-BEING

Student Health Services

### AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL INFORMATION

Note: We will not send medical records via fax or mail outside of the U.S.

Name: \_\_\_\_\_

Student ID: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**I hereby authorize** UCSD Student Health Services (SHS) to:

- Release information to:  Obtain information from:  Exchange information with:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Type of Disclosure:**  Verbal communication  Copies of records

**Information to be released:**

- All medical records  X-rays/labs  
 Visit notes  Immunization records  
 Other as specified: \_\_\_\_\_

**Sensitive Issues:** You must specifically authorize the disclosure of the following types of information.

- \*\*Initial** next to each item that applies: \_\_\_\_\_ HIV/AIDS information  
\_\_\_\_\_ Drug/alcohol/substance abuse diagnosis/treatment  
\_\_\_\_\_ Genetic test results  
\_\_\_\_\_ Gender issues  
\_\_\_\_\_ Mental health (does not include CAPS records)  
\_\_\_\_\_ Psychiatric medication records

**For the following purpose(s):**

- Coordination of treatment/care  
 Administrative and/or academic coordination  
 Other \_\_\_\_\_

**Requested method of delivery:**

- Fax  
 Mail  
 Patient pick up  
 Other authorized party pick up:

Name: \_\_\_\_\_ Student ID/License #: \_\_\_\_\_

## MEDICAL RECORD FEE SCHEDULE

There is no charge for records to be sent to another health care provider. Records released directly to the patient or an authorized third party may be subject to charges; the first 20 pages are at no cost, and after the 20th page, there will be charge of \$0.25 per page. We accept checks (pay to the order of UC Regents), or you may pay in person by credit card.

***You have one (1) business day to revoke your record request. Thereafter, you will be responsible for all fees incurred by your request.***

**NOTICE:** UCSD SHS, and other health care providers and organizations 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.

I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form and that I may revoke my consent at any time (except to the extent that the information has already been released). This revocation must be delivered in writing to UCSD SHS Medical Records.

**THIS CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF YOUR SIGNATURE.**

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Signature – **(Electronic/Digital Signatures Not Accepted)**

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Date

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Print Name