UNIVERSITY HEALTH SERVICES *Tang Center*

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Use this form for release of medical information. Information pertaining to Counseling, Psychiatry, Social Services, and Drug and Alcohol Counseling is released separately. Contact CPS or Social Services for information on mental health and counseling releases.

Name: ______________________ , ____________________ ___ Date of Birth: ___/___/______
Last First MI MM/DD/YYYY

Medical Record #: ________________________ SID #: _________________________
from Gold Tang Center Card from Student ID Card

I authorize:
(Person or facility which has health information)
UC Berkeley University Health Services
Medical Records
2222 Bancroft Way, Tang Center
Berkeley, CA 94720-4300

To release health information to:
(Person or facility to receive health information)
Name: ______________________
Address: ______________________
____
Phone: ______________ Fax: ______________

Please specify the health information you authorize to be released:

Type(s) of health information: ______________________

Specify date(s) of treatment or time period: ______________________

Please describe the purpose of this release: ______________________

The following information will not be released unless you specifically authorize it by *initialing* the relevant line(s) below:

_____ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §120980(g)).
Initial

_____ I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)).
Initial

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.

Please read the important notice concerning your rights on the following page.

Signature:

Signature (Patient, Parent, Guardian)	Print Name	Date Time
Relationship to Patient (Parent/Guardian/ Conservator/Patient Representative)	Witness (if patient unable to sign) or Interpreter	Phone Number

NOTICE: UHS 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) 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, University Health Services, 2222 Bancroft Way, Berkeley, CA 94720-4300. The revocation will take effect when UHS receives it, except to the extent UHS or others have already relied on it.

You are entitled to receive a copy of this Authorization.