

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information

Name (Last, First, Middle) _____

Address _____

Phone _____ Student ID _____ Date of Birth _____

Authorization

Patient hereby authorizes University Health Services to (check all that apply):

- Release Information to: _____ Request Information from: _____
 Mutually Exchange *Verbal* Information with: _____

Name _____ Phone: _____

Address _____ Fax: _____

City _____ State _____ Zip Code _____

Type of Disclosure: Verbal Communication Copies of Records (Please note, when possible, and unless otherwise requested, copies will be released electronically via USB drive.)

Health Information Authorized to be Released (Please check all that apply.)

- Immunization Records (does not include Mandatory TB/Immunization Program Records)
 Radiology Records Billing Records Insurance Referrals
 Counseling and Psychological Services (CAPS) Records Social Services Records
 Psychiatry Records Laboratory Results
 SHIP Waiver Information (applies to verbal disclosure only)
 Behavioral Health Records (connected to services in primary care; not related to CAPS)
 Other (Specify): _____

- MEDICAL RECORDS (May include incidental drug/alcohol and behavioral health information documented by primary care, urgent care, or specialty practitioner. *You may request to exclude the entire visit note that contains such information.* Medical records do NOT include counseling, psychiatry, social services, or billing records. You may select those above.)

Specify date(s) of treatment or time period (Note: Unless otherwise specified, **only last two years of records are released**):

Purpose of Release

Please state the purpose for the request: Continuity of Care Insurance Purpose

Legal Matter Personal Use Other: _____

Specific Authorization

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. (Cal. Health & Safety Code §120980(g).)

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

Expiration and Validity of Authorization

Unless otherwise revoked, this Authorization is effective immediately and shall remain in effect until _____. If no date is indicated, this Authorization will expire twelve (12) months after the date of requestor's signature at the bottom of this form.

For copies of records, we will not release records for services provided after the signature date below unless specifically authorized and approved.

There may be a fee for your request. For current fees and fee payment options please see <https://uhs.berkeley.edu/medical/health-records>. A portion of any fees due may be required in advance of your record production. For records scheduled to be picked up in person: records not picked up within 60 days after they are produced will be destroyed. You will be charged the preparation fee regardless of whether or not record was picked up.

A copy of this Authorization shall be valid as an original.

Signature of the Patient or patient’s legal representative

Date

Printed name of signatory

Witness (if patient is unable to sign) or Interpreter

Relationship to patient (if signed by other than patient)

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 using the appropriate form available at the Health Records department or online at: <https://uhs.berkeley.edu/medical/health-records>.

The revocation form must be signed by you or your patient representative, and delivered to Health Records Department, 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 upon request.