

UC Hastings College of the Law, Student Health Services

AUTHORIZATION FOR RELEASE OF MEDICAL AND MENTAL HEALTH INFORMATION

Date:
SID#:
Year: 1L 2L 3L LLM Visiting/Exchange

Name (Print)

Student ID Date of Birth

Address City State Zip Phone

I authorize: Mutual exchange of information (Person or facility which has medical and mental health information)

Name Address: Phone: Fax:

To release medical and mental health information to: (Person or facility to receive health information)

Name Address: Phone: Fax:

Type of disclosure: Verbal Information Copies of records

Please specify the information you authorize to be released:

- Mental health information (Subject to the Lanterman-Petris-Short Act, Welf & Inst. Code §5000 et seq.).
Medical (This may include drug/alcohol and mental health information documented by a primary care practitioner)
HIV/AIDS test results (Health and Safety Code §120980(g)).

Type(s) of information, if not specified above (e.g. Summary Report):

Specify date(s) of treatment, time period or condition:

Limitations upon disclosure:

The purpose of this release is:

- At the request of the client/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.

Client/Patient/Patient Representative Signature

Relationship to Client/Patient

Date

NOTICE: UC Health Services and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential.

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) 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 client/patient representative, and delivered to UC Hastings Student Health Services, 200 McAllister Street, San Francisco, CA 94102. The revocation will take effect when Student Health Services receives it, except to the extent Student Health Services or others have already relied on it. You are entitled to receive a copy of this Authorization.