

**PATIENT NAME** \_\_\_\_\_

**Student ID #** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

University of California, Davis  
**Student Health and Counseling Services**  
**Release of Information Department**  
One Shields Avenue, Davis, CA 95616  
Phone (530)752-6129 Fax (530)752-5587

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

**I authorize:** Student Health and Counseling Services, University of California, Davis

Name of person and/or facility that has information

One Shields Avenue Davis, California 95616 530-752-6129 530-752-5587  
Street Address, City, State, Zip Code Phone Fax

**To release health information to:**

Specify name/title of person and/or facility to receive health information

Street Address, City, State, Zip Code Phone Fax

**TYPE OF DISCLOSURE:**  Copies  Verbal  Inspection  Summary  Letter

**Please specify the health information you authorize to be released:**

MEDICAL  MENTAL HEALTH

**Type(s) of health information:** \_\_\_\_\_

**Date(s) of treatment:** \_\_\_\_\_

**The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:**

- I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. 2.34 and 2.35).
- I specifically authorize the release of HIV/AIDS test results (Health and Safety Code 120980(g)).
- I specifically authorize the release of genetic testing information (Health and Safety Code 124980(j)).

**(Please complete back of form)**

**Student Health and Counseling Services, University of California, Davis**

**The purpose of this release is for (check one or more):**

At the request of the patient/patient representative

Other (state reason)\_\_\_\_\_

**NOTICE**

SHCS 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 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: Custodian of Records, SHCS, One Shields Avenue, University of California, Davis, CA 95616.

The revocation will take effect when SHCS receives it, except to the extent SHCS or others have already relied on it.

**You are entitled to receive a copy of this Authorization.**

**EXPIRATION OF AUTHORIZATION**

Unless otherwise revoked, this Authorization expires \_\_\_\_\_(insert applicable date). If no date is indicated, the Authorization will expire 12 months after the date of signing this form.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature (Patient, Parent, Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Relationship to Patient (Parent, Guardian,  
Conservator, Patient Representative)

Witness\_\_\_\_\_  
(only if patient unable to sign) or Interpreter