SHCS Staff: _____

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:
Graduate Studies at UC Davis
Specify name/title of person and/or facility to receive health information

250 Mrak Hall, One Shields Ave Davis CA 95616 (530)752-2300
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: Information relevant to the presenting concern

Date(s) of treatment: 2023-2024

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