University of California, Irvine - Counseling Center
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Tel: (949) 824-6457 Fax: (949) 824-6586

AUTHORIZATION FOR RELEASE/EXCHANGE OF MEDICAL AND MENTAL HEALTH INFORMATION

Name_____Date of Birth_____UC ID# _____

Address _____

City_____State_____Zip_____Phone number_____

Authorization for Release/Exchange of Information: I voluntarily authorize the UCI Counseling Center to

□ **release** to or □ **exchange** my health information with the recipient that I have identified below:

_____
Person, provider, or agency to receive/exchange information

_____
Address

_____
City, State, Zip Code

_____
Phone

_____
Fax Number (if information is to be faxed)

Type of Disclosure: ☐ Verbal Information ☐ Secure Electronic Communication
☐ Letter/Treatment Summary ☐ Copies of records

Specific Authorizations

I specifically authorize the release of the following information by **checking** next to the relevant box(es) below:

☐ Mental health information, diagnosis and treatment

☐ Medical information, diagnosis and treatment

☐ Drug and alcohol abuse information, diagnosis or treatment.

☐ HIV/AIDS testing information.

☐ Correspondence and records from my other health care providers that the above-named health care providers may hold.

☐ Disclosure will be limited to: _____

_____

Purpose of Release: I understand that the specific purpose of this Authorization is:

☐ Coordination of treatment

☐ Other (state reason) _____

Expiration of Authorization: Unless otherwise revoked, this Authorization expires on_____. If no date is indicated, this Authorization will remain in effect for one year from the date this Authorization is signed.

Notice: Many 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: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice. The revocation will not have any effect on any action already taken by my health care provider in reliance on this Authorization before he/she received my written notice of revocation.

I may contact my health care provider with any questions about the privacy of my health information. I understand that I have the right to receive a copy of this authorization.

A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

_____	_____	_____
Client/Patient Name (print above)	Signature	Date

If client/patient is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Legal Representative (print name)	Relationship	Signature	Date

_____	_____	_____
Witness (print name)	Signature	Date