UCI Counseling Center

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AUTHORIZATION TO RELEASE/EXCHANGE MEDICAL AND MENTAL HEALTH INFORMATION

Name_____Date of Birth_____UC ID# _____

Address _____

City_____State____Zip_____Phone number_____

I AUTHORIZE THE COUNSELING CENTER TO RELEASE/EXCHANGE HEALTH INFORMATION WITH:

_____

Person, provider, or agency to release/exchange information

_____

Address, City, State, Zip Code

_____

Phone

_____

Fax Number or Email address (if information is to be faxed or emailed)

**Please note that requests are processed within 15 days of the date they were received.*

Type of Disclosure: ☐Verbal ☐Written

Type(s) of Information (e.g., Summary, Report, Letter, Copies of Record):

Method of Delivery for Written Information:

☐ *The Counseling Center has several available delivery options. I understand that, if chosen, delivery via eFax and Encrypted Email carries security risks.*

Specific Authorizations

Please specify the health information you authorize to be exchanged:

- ☐ Mental health information, diagnosis and treatment
- ☐ Medical information, diagnosis and treatment
- ☐ Drug and alcohol abuse information, diagnosis or treatment.
- ☐ HIV/AIDS testing information.
- ☐ Genetic 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