UC San Diego
STUDENT HEALTH AND WELL-BEING
Student Health Services

9500 Gilman Drive #0039, La Jolla, CA 92093
Phone: (858)534-2139
Fax: (858)534-7545

AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL INFORMATION

Note: We will not send medical records via fax or mail outside of the U.S.

Name: _____

Student ID: _____ Birth Date: _____

Address: _____
Street City State Zip

Phone Number: _____ Email: _____

I hereby authorize UCSD Student Health Services (SHS) to:

☐ Release information to: ☐ Obtain information from: ☐ Exchange information with:

Name: _____
Address: _____
Telephone: _____ Fax: _____

Type of Disclosure: ☐ Verbal communication ☐ Copies of records

Information to be released:

☐ **All** medical records
☐ Visit notes
☐ Other as specified: _____
☐ X-rays/labs
☐ Immunization records

Sensitive Issues: You must specifically authorize the disclosure of the following types of information.

****Initial** next to each item that applies:

_____ HIV/AIDS information
_____ Drug/alcohol/substance abuse diagnosis/treatment
_____ Genetic test results
_____ Gender Affirming Care
_____ Mental health (does not include CAPS records)
_____ Psychiatric medication records
_____ Reproductive Health
(birth control pill, IUD, nexplanon, emergent contraception, pregnancy options counseling, abortion)

For the following purpose(s):

☐ Coordination of treatment/care
☐ Administrative and/or academic coordination
☐ Other _____

Requested method of delivery:

☐ Fax
☐ Mail
☐ Patient pick up
☐ Third party pick up:
Name: _____
Student ID/License #: _____

MEDICAL RECORD FEE SCHEDULE

There is no charge for records to be sent to another health care provider. Records released directly to the patient or an authorized third party may be subject to charges; the first 20 pages are at no cost, and after the 20th page, there will be charge of $0.25 per page. We accept checks (pay to the order of UC Regents), or you may pay in person by credit card.

You have one (1) business day to revoke your record request. Thereafter, you will be responsible for all fees incurred by your request.

NOTICE: UCSD SHS, and other health care providers and organizations 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.

I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form and that I may revoke my consent at any time (except to the extent that the information has already been released). This revocation must be delivered in writing to UCSD SHS Medical Records.

THIS CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF YOUR SIGNATURE.

Signature – **electronic/digital signatures not accepted**

Date

Print Name