UCMERCED Student Health Services

H. Rajender Reddy Health Center,
5200 North Lake Rd.,
Merced, Ca, 95343
Phone: (209) 228-2273
Fax: (209) 228-7650

AUTHORIZATION FOR RELEASE OF FINANCIAL INFORMATION

This authorization is for the release of financial and insurance related information only. Release of medical records requires completion of a separate authorization.

Patient Information

Last Name: _____ First Name: _____ Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Student ID: _____ Date of Birth: _____

Authorization

Patient hereby authorizes the staff of UC Merced Student Health Services to release financial information regarding Patient's Student Health Insurance, waiver, and medical claims, to:

Name: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip Code: _____

Patient Rights

This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except when the authorization is for 1) obtaining information in connection with eligibility or enrollment in a health plan, 2) determining an entity's obligation to pay a claim, or 3) creating health information to provide to a third party.

Under no circumstance is the patient required to authorize the release of financial records. The requestor may revoke this authorization at any time. To do so, the requestor must revoke this authorization in writing and submit the revocation to UC Merced Health Services, 5200 North Lake Rd., Merced, Ca, 95343. This revocation will take effect when UC Merced Student Health Services receives it, except to the extent that UC Merced Student Health Services or others have already relied on it.

Patient is entitled to a copy of this authorization upon request. This authorization will expire 12 months after the date of the requestor's signature at the bottom of this form. A copy of this authorization shall be valid as an original.

_____ _____
Signature of patient or patient's legal representative Date

_____
Printed name of signatory

_____
Relationship to patient (if signed by other than patient)