UNIVERSITY OF CALIFORNIA, MERCED
H. RAJENDER REDDY HEALTH CENTER
5200 North Lake Road ▯ Merced, CA 95343
(209) 228-2273 Fax (209) 500-6334

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name: _____ DOB: _____ Cell Phone #: _____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City State Zip Code

Phone: _____ FAX: _____

PLEASE SEND INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City State Zip Code

Phone: _____ FAX: _____

I AUTHORIZE the following information to be disclosed for the following date(s): _____
(**Initial all that apply**)

_____ Progress Notes
_____ Immunization Record
_____ Lab Test
_____ TB Test
_____ HIV Record
_____ STD Record
_____ Psychiatric/Mental Health
_____ Alcohol/Substance Abuse
_____ Billing Records
_____ Other _____
_____

REASON for disclosure of health information: (**Initial one**)

_____ Personal Use
_____ Continuing Care
_____ Legal
_____ Job
_____ School
_____ Insurance
_____ Other _____
_____
_____

EXPIRATION of this Authorization: (**Initial one**)

_____ 90 days after signature date _____ On this date: _____
_____ When this event happens: _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below.*
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is no longer protected by University of California, Merced - Student Health Services.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

_____ Date: _____
Student Signature (Parent or Legal Representative, if applicable) Relationship

*I wish to withdraw this authorization: _____ Date: _____

Please allow ten (10) business days for staff to process your request. There is a fee schedule for record requests not associated with Continuity of Care initiated by UCM Health Services. All fees must be paid prior to records release.

For Office Use:
__ Pick-Up Records __ Mail Records __ FAX Records

Fee Paid Yes / NA $ _____

Date _____ Initial _____

Name: _____
Last First MI
DOB: _____ Sex: __ M __ F
MM/DD/YYYY
ID#: _____