UNIVERSITY OF CALIFORNIA, LOS ANGELES UCLA

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AUTHORIZATION FOR RELEASE OF MEDICAL AND MENTAL HEALTH INFORMATION

Name: _____

UC ID #: _____ Date of Birth: ___/___/_____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I authorize: (Person or facility which has and medical and mental health information)

☐ To release or ☐ to exchange medical information to/with: (Person or facility to receive health information)

Name: UCLA–Counseling & Psychological Services

Address: John Wooden West, Box 951556

Los Angeles, CA 90095-1556

Phone: 310-825-0768

Fax: 310-206-7365

Name: _____

Address: _____

Phone: _____

Fax: _____

Type of disclosure:

☐ Verbal Information ☐ Copies of records ☐ Letter ☐ Proof of Attendance

Please specify the information you authorize to be released:

☐ Mental health information (Subject to the Lanterman-Petris-Short Act, Welf & Inst. Code §5000 et seq.).

☐ Medical (This may include drug/alcohol and mental health information documented by a primary care practitioner)

☐ Drug and alcohol abuse, diagnosis or treatment information subject to federal law (42 C.F.R. §§2.34 and 2.35).

☐ HIV/AIDS test results (Health and Safety Code §120980(g)).

Type(s) of information, if not specified above (e.g. Summary Report)_____

_____

Specify date(s) of treatment, time period or condition:_____

_____

Limitations upon disclosure: _____

_____

The purpose of this release is:

☐ At the request of the client/patient/patient representative

☐ Other (state reason) _____

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this Authorization expires on _____.
If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____

Client/Patient/Patient Representative Signature

_____ _____

Relationship to Client/Patient (if other than Client/Patient) Date

NOTICE: UCLA-CAPS and many other 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: This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) solely to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your client/patient representative, and delivered to:

UCLA Counseling and Psychological Services, John Wooden Center West, Campus
or mail to: Box 951556, Los Angeles, CA 90095-1556 .

The revocation will take effect when UCLA-CAPS receives it, except to the extent UCLA-CAPS or others have already relied on it. You are entitled to receive a copy of this Authorization.

You have the right to receive written acknowledgment from a non-medical recipient of the information being released pursuant to this authorization agreeing to abide by the restrictions contained in this release. By signing here, you waive the right to receive such a signed written agreement from the intended recipient: _____Date_____