University of California, Santa Cruz
Disability Resource Center (DRC)
1156 High Street, Santa Cruz, CA 95064

TEL: (831) 459-2089
FAX: (831) 459-5064
EMAIL: drc@ucsc.edu

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name _____Student ID# _____ Date of Birth _____

Address _____ City _____ State _____

ZIP Code:_____ Phone_____

I HEREBY AUTHORIZE
(name of person or facility which has information):

University of California, Santa Cruz

Disability Resource Center (DRC)

1156 High Street

Santa Cruz, CA 95064

(831) 459-2089

(831) 459-5064 Fax

☐To release or ☐To exchange information to/with:

☐ College—Academic _____
☐ College—Res Life _____
☐ Academic Department _____
☐ Parent(s)
☐ Clinical Provider
☐ Other _____
(name of person or facility to receive information)

Name or facility to receive information:

_____

Address _____

_____

Phone_____

Fax _____

Type of Disclosure *(check all boxes that apply)**:*** Verbal Information : ☐
Written Information: ☐ Medical Record ☐ Summary Letter ☐ Other (specify):

Please specify the information you authorize to be released:

☐ LD Assessment (aptitude, achievement, information processing scores and narrative report)
☐ Medical Paperwork (This may include drug/alcohol and mental health information documented by a primary care practitioner).
☐ ADD/ADHD Evaluation
☐ HIV/AIDS results (Health and Safety Code § 120980 (g)) **[Will NOT be released unless specified]**
☐Other information, if not specified above: _____
_____
Limitations upon disclosure: _____
_____

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State the purpose of this release: _____

_____

_____

_____

_____

NOTICE:

UC Santa Cruz Disability Resource Center 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.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your representative, and delivered to: **Our address on page 1.**
The revocation will take effect when DRC-UCSC receives it, *except* to the extent DRC-UCSC or others have already relied on it. You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

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

_____ _____
Print Name Signature (Student, Guardian)

_____ _____ _____
Date Time Relationship to Student (If Applicable)

_____
Witness (only if patient unable to sign) or interpreter

For UC Santa Cruz DRC Office Use Only:

Records Request:
☐ Mailed to address on page 1 ☐ Faxed to number on page 1
Initials: _____ Date: _____
Records Released:
☐ (E) Mailed to student ☐ Faxed to student ☐ Handed to student
☐ Left in pick-up box Initials: _____ Date: _____ # of pages: _____

Request for Verbal Information Only:
☐ Note entered in DRC's CMS:
Initials: _____ Date: _____
Records not Released:
Reason:_____ Initial: _____ Date:_____