UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

LIMITED AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Instructions:

1. Complete all BLANK sections. SIGN and DATE the form.

2. Send a copy of the completed form to UCEAP when instructed to submit health clearance paperwork by the deadline for your program in the EAP Pre-Departure Checklist.

Completion of this document authorizes the disclosure and/or use of health information about you in connection with your UCEAP health clearance or during a medical emergency abroad.

Use and Disclosure of Health Information

I, _____, ("Student"), participating in

_____ hereby authorize all physicians, all health
EAP Program Name (Country/Host University/Term)

practitioners, and all psychotherapists, who have provided care to me within the last twelve (12) months, including each person listed on the last page of this limited authorization, to release to University of California Education Abroad Program Universitywide Office, 6950 Hollister Avenue, Suite 200, Goleta, CA 93117 and to the Tang Center, 2222 Bancroft Way, Berkeley, CA 94720, the following information:

a. ☒ All health information pertaining to my medical history, mental or physical condition and treatment received — ***OR***

☐ Only the following records or types of health information (including any dates):

_____

_____

b. I specifically authorize release of the following information (check as appropriate):

☒ Mental health treatment information[1]

☐ HIV test results

☒ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes as defined by HIPAA (45 C.F.R. section 164.501).

c. Further, I authorize the University of California, Education Abroad Program (UCEAP) and its agents to contact my emergency contact as indicated on the emergency form, in connection with my general welfare abroad.

[1] If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

Purpose

Purpose of requested use or disclosure: ☒ patient request *OR* ☒ other: To obtain an EAP health clearance, to obtain information regarding Student's compliance with any conditional health clearance provisions during EAP, for use in seeking health care for Student while abroad as part of EAP, and to notify the emergency contact on record at EAP of any health emergency Student suffers while participating in the EAP program

Expiration

This Limited Authorization expires upon completion of Student's participation in EAP.

My Rights

I may refuse to sign this Limited Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2] However, this Limited Authorization must be signed to obtain a health clearance to participate in UCEAP.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this Limited Authorization at any time, but I must do so in writing and submit it to the following addresses: Inés DeRomaña, University of California Education Abroad Program Universitywide Office, 6950 Hollister Avenue, Suite 200, Goleta, CA 93117 and University Health Services – Tang Center, 2222 Bancroft Way, Berkeley, CA 94720.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Limited Authorization.

I have a right to receive a copy of this Limited Authorization.[3]

Information disclosed pursuant to this Limited Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

A scanned copy attached to an email message, a facsimile, or a photocopy of this signed and completed Limited Authorization may be used as if it is a signed and completed original.

Signature

Date: _____ Time: _____ am/pm Signature: _____

(patient/representative/spouse/financially responsible party)

LIST OF HEALTH PROVIDERS

List each physician, each health practitioner, and each psychotherapist, who has provided care to Student within the last twelve (12) months:

Please print.

☒ UC Student Health Service

☒ UC Student Counseling Center

[2] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[3] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 C.F.R. Section 164.508(d)(1), (e)(2)).

Name _____

Address _____

Telephone _____

Name _____

Address _____

Telephone _____

Name _____

Address _____

Telephone _____

Name _____

Address _____

Telephone _____