Authorization to Release Immunization and Health Records

Student Name: _____ **SID:** _____

Release of Information

I hereby authorize the UCR School of Medicine to release my immunization and health records maintained by the Office of Student Affairs to any clinical site or other entity as is necessary for the purposes of furthering my medical education. Specifically, the immunization and health records that can be released are as follows:

- O Measles Serology and/or Immunization History
- O Rubella Serology and/or Immunization History
- O Mumps Serology and/or Immunization History
- O Varicella Serology and/or Immunization History
- O Hepatitis B Serology and/or Immunization History
- O Tdap Vaccination History
- O Tuberculosis Screening History
- O Influenza Vaccination History
- O SARS COVID 19 Vaccination History
- O Background Check Verification/Report
- O Drug Screen Panel Results (as processed through CastleBranch)

This authorization for release of information expires _____.

I understand that I have a right to revoke this authorization by providing notice to the School of Medicine Registrar. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. I also understand that I have a right to a copy of this authorization.

UC RIVERSIDE | School of Medicine

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Student: _____ Date: _____
Signature

Witness: _____ Date: _____
Signature

Witness Name:_____