Authorization for Request or Release of Medical Information

California State University, Chico • Student Health Center
400 W 1st St, Chico, CA 95929-0777 • Phone: 530-898-5241 • Fax: 530-898-4057

This authorization form has been specifically designed to comply with all state and federal regulations pertaining to the confidentiality of health information. In order for this authorization to be considered valid, it must be completed in its entirety.

I voluntarily authorize the release of information and/or copies of medical records for the following patient:

Patient's Full Name: _____ DOB: _____

Records to be released FROM: □ California State University, Chico Student Health Center

OR: □ Name of individual or agency: _____
Complete Address: _____
City, State, Zip: _____
Fax #: _____ Phone #: _____

Records to be released TO: □ California State University, Chico Student Health Center

OR: □ Name of individual or agency: _____
Complete Address: _____
City, State, Zip: _____
Fax #: _____ Phone #: _____

For the following purpose: □ Continuity of Care □ **OR**: _____

Information to be released: □ All Records **OR** □ Records pertaining only to the following:
□ Progress notes □ Laboratory test results □ X-ray reports/films □ Other health information
Date(s): _____ _____ _____ _____

Release of the following medical information requires additional authorization:

□ Drug and/or Alcohol information or treatment Dates _____ Patient initials _____
□ Mental Health Records Dates _____ Patient initials _____
□ HIV/AIDS testing/status Dates _____ Patient initials _____

This information is for use by the above named recipient only. It cannot be given to another individual or agency without the patient's consent. This authorization will expire six months from the date below. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact CSUC Student Health Center Medical Records. I understand that I am entitled to receive a copy of this authorization.

Patient Signature: _____ Date: _____
Patient Name: _____ Phone #: _____ DOB: _____
Witness Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Records mailed/faxed: ___/___/___ By: ____ Payment for copies received: ___/___/___ By: ____
Records sent for: ___/___/___ By: ____ Records hand-carried: ___/___/___ By: ____
Patient to pick up on: ___/___/___
Other remarks:

*** Please note – CSU, Chico Student Health Center can only accept records in paper format. ***