Authorization for Request or Release of Medical Information

California State University, Chico • WellCat Health Center
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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: _____

I Authorize *California State University, Chico WellCat Health Center* to:

□ *Release information TO*: **OR**: □ *Request information FROM*:

Name: _____

Complete Address: _____

City, State, Zip: _____

Fax #: _____ Phone #: _____

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

Information to be released: □ **All Records for the most recent 12 months of services**

OR: □ 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 of service _____ Initials ____

□ Mental Health Records Dates of service _____ Initials ____

□ HIV/AIDS testing/status Dates of service _____ Initials ____

□ I authorize disclosure of my protected health information generated after the date of my signature, until the designated expiration as noted below, or revocation, whichever occurs first. 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 WellCat 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: ___/___/___ Ongoing request expiration: ___/___/___ By: ____

Other remarks:

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