



CALIFORNIA STATE UNIVERSITY, LONG BEACH

STUDENT HEALTH SERVICES

Accredited by the Accreditation Association for Ambulatory Health Care, Inc.

1250 Bellflower Boulevard Long Beach, California 90840-0201 (562) 985-4771 FAX: (562) 985-1644

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, hereby, authorize the California State University, Long Beach Student Health Service to RELEASE the following information from my medical record:

___ Complete Medical Record ___ Other: _____

THE PURPOSE OR NEED FOR THE RELEASE
___ Personal Records
___ Other, describe _____

I release the CSULB Student Health Service from any liability or legal responsibility that may arise from this authorization. This release is valid for 1 year (from the date of patient signature) and may be revoked at any time with a written request.
I AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO:
Name _____
Address _____
City: _____ State: _____ Zip: _____

___ I request a copy of this release of information form.

Patient Name: _____ Campus ID#: _____
First Middle Last

Patient Address: _____
City: _____ State: _____ Zip: _____

Current Telephone: (____) _____ - _____ Date of Birth: ____/____/____

Student Signature Date Parent or Guardian Signature Date
(required if under 18)

For Office/Records Use Only: Date Released: ____/____/____ Released By: _____