CALIFORNIA STATE UNIVERSITY, LONG BEACH

STUDENT HEALTH SERVICES

1250 Bellflower Blvd. Long Beach, CA 90840-0201 (562) 985-4771 **FAX: (562) 985-1644**

AUTHORIZATION FOR THE RELEASE OR REQUEST OF MEDICAL INFORMATION

Patient Name:______________________________ Campus ID#:_______________

First Middle Last

Patient Address:____

City:__________________________________ State:________ Zip:_________

Telephone: (____)______-_________ Date of Birth: ____/____/_______

Type of Access Requested: ☐Copies ☐Verbal Exchange of Medical Information

I, hereby, authorize California State University, Long Beach Student Health Service to:

☐ **Release** medical information to: or ☐ **Request** medical information from:

Name:____

Address:____

Telephone: (____) _______-________ Fax: (_____) _______-________

Specific Information Release:

☐ Complete Medical Records_______ ☐ Lab/Pathology ___________ ☐HIV________

☐ Immunization Records __________ ☐ X-ray__________________

☐ Other _________________________ ☐ Psychiatric visit notes_____________________

Check one of the following if releasing records:

☐ Please call me when records are ready to be picked up ☐ Mail certified

☐ Please fax to ______________________ (Note: limited medical records faxed)

For the following purpose: ☐ Coordination of Treatment/Care ☐ Personal Records

☐ School/Employment ☐Other, describe _________________________________

I understand the following:

1. The recipient of the protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
2. I understand any disclosure of this information carries a potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
3. Signing this Authorization is not required as a condition to obtaining treatment at Student Health Services. A copy of this Authorization will be provided by Student Health Services upon request.
4. Revocation of this Authorization may be done at any time by mailing or personally delivering a signed, written notice of revocation to the Medical Records Dept. of Student Health Services. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this Authorization.
5. This Authorization is valid for this request only.

This Release is executed in conformity with Cal. Civ. Codes Section 56.11 Et Seq.

Authorization will expire on ____/___/___ or 90 days from date of your signature.

________________________________ ______________________ _____/_____/_____

Student Signature or Legal Representative Print Name Date

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

Date left at Front Office for pick up: ____/____/_____ Date faxed/mailed: ____/____/______