Authorization for Release of Medical Information

Sonoma State University Student Health Center
1801 East Cotati Ave., Rohnert Park, CA 94928 ** Phone: 707 664-2921 ** Fax: 707 664-2925

I voluntarily authorize the release of information from my medical records only as specified below. I understand that:

1) This authorization will expire three months from the date signed or earlier upon my written revocation.
2) Expiration or cancellation doesn't apply to records sent prior to expiration or receipt of my revocation.
3) I am entitled to a copy of this authorization.

Patient's Full Name (list other names used**):** _____

Student ID Number _____ Date **of Birth** _____ **Phone**: (___) _____

Records to be Released From: (Disclosing Party)

Name of Organization &/or Clinical Provider: _____

Phone: (_____) _____ **FAX: (_____)_____**

Address: **Street:** _____

City: _____ **State:** _____ **Zip:** _____

Records to be Released To: (Recipient)

Name of Organization &/or Clinical Provider: _____

Phone: (_____) _____ **FAX: (_____) _____**

Address: **Street:** _____

City: _____ **State:** _____ **Zip:** _____

For the Following Purpose: _____

Specify Medical Information to be Released:

☐ Pap Smear reports **ONLY** (Dates): _____ ☐ Immunization records **ONLY:** _____

☐ Medical records: (Indicate Applicable Dates): _____

☐ Lab reports: ☐ X-ray/Imaging reports: (Type of Test & Date): _____

☐ Records pertaining only to: _____

Release of the Following Medical Information Requires Additional Authorization (Specify & initial below.)

☐ Drug &/or Alcohol Information: **Patient's Signature: _____**

☐ Mental Health /Developmental Disability: **Patient's Signature: _____**

☐ STI Test Results/Disease including HIV : **Patient's Signature: _____**

Limitations: Disclosure of SSU Student Health Center Medical Records information is for medical treatment purposes only. In accordance with the F**amily Educational Rights and Privacy Act (FERPA) f**urther disclosure is of this health information by the recipient to other individuals or entities is not permitted.

☐ **Limited to Discussion of Care Only: Pt. Initial _____** I am consenting **ONLY** for my provider to verbally discuss the medical circumstance indicated above with the indicated recipient. **Do NOT send copies of medical records.**

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Upon the patient's written authorization, the SSU Student Health Center will release medically necessary records to a medical provider or organization by mail for medical treatment purposes. A charge will apply for records requested for legal or business purposes, for the patient's personal use, or by individuals no longer enrolled at SSU.