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)** further disclosure 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.