



# SACRAMENTO STATE

Student Health & Counseling Services

6000 J Street, Sacramento, CA 95819-6045

(P) 916.278.6461 | (F) 916.278.7359 | www.csus.edu/hlth

## Medical Information Release Consent

**Instructions:** The patient must complete this form in its entirety in order for Student Health & Counseling (SHCS) to release or request any medical information. Please be specific in stating the nature of the information to be released and the purpose for which it is requested.

I Authorize:  Student Health & Counseling

OR  Name of Individual or Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### To Release the following:

Entire Chart

All treatment records for dates beginning \_\_\_\_\_ and ending on \_\_\_\_\_

Lab reports dated: \_\_\_\_\_

X-Ray reports dated: \_\_\_\_\_

X-Ray Films dated: \_\_\_\_\_

HIV Test results dated: \_\_\_\_\_

Other \_\_\_\_\_

**TO:**  California State University, Sacramento  
Student Health & Counseling Services  
6000 J Street  
Sacramento, CA 95819-6045  
(T) 916.278.6461 (F) 916.278.7359

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Reason for Release of Information: \_\_\_\_\_

This information is intended only for the named recipient herewith. It may not be given to another individual or agency without the patient's consent. This authorization will expire one month from the date below. I understand that I may revoke this authorization and **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 by CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact Student Health & Counseling Services Medical Information Coordinator.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Student ID #: \_\_\_\_\_ DOB: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE ONLY:**  APPROVED \_\_\_\_\_

RECORDS DISPOSITION:  Mailed  Faxed  Hand-Carried \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ By: \_\_\_\_\_

Patient pick up on: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ By: \_\_\_\_\_

Return Records to SHC PVDR: \_\_\_\_\_

Other Remarks: \_\_\_\_\_