



California State University,

Student Health Center
6000 J Street
Sacramento, CA 95819-6045

Phone 916-278-6461
Fax 916-278-2033 or
916-278-7359

SACRAMENTO STATE

Consent for the Release of Medical Information

Instructions: The patient must complete this form in its entirety in order for the Health Center to release or request any medical information. Please be specific as to the nature of the information to be released

I Authorize: The CSUS Student Health Center

OR (Name of Individual or Agency) _____
(Complete address) _____
(City, State, Zip) _____

To Release the Following: (Please Check)

Entire chart
 All records for my treatment for dates beginning _____ & ending on _____
Lab Reports dated _____
 X-Ray Reports dated _____
 X-Ray Films dated _____
H IV test results dated _____
O ther _____

To: California State University, Sacramento _____
Student Health Center
6000 J Street
Sacramento, CA 95819-6045
Phone: (916) 278-6461
FAX: (916) 278-7359

For the purpose of: _____

This information is for use by the above named recipient only. It cannot be given to another individual or agency without the patient's consent. This authorization will expire two months from the date below, or on _____. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I 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 in 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 can contact the CSUS Student Health Center Medical Records Supervisor.

Patient Signature: _____ Date: _____

Printed Name: _____ SSN#: _____

Witness: _____ Date: _____

FOR OFFICE USE ONLY:

Approved: _____ Records Mailed ____/____/____ By: _____

Reco rds Sent For ____/____/____ By: _____

Patient to pick up on: _____ Hand Carried ____/____/____ By: _____

Reco rds Faxed ____/____/____ By: _____

Return Records to SHC PVDR _____

Other remarks _____