SACRAMENTO STATE
Student Health & Counseling Services

California State University, Sacramento
Student Health & Counseling Services
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AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client/Patient Information	Name: _____ Date of Birth: _____ Student ID: _____ Purpose of Disclosure: _____ (Examples: Coordination of Care, Evaluation, Academic Support, Documentation, Referral, Personal)
I Authorize (Who has the information you want released) ***Must be filled out completely***	Agency/Name: _____ Phone: _____ Address: _____ Fax: _____ City: _____ State: _____ Zip: _____
Receiving Party (Where do you want the information to go) ***Must be filled out completely***	Agency/Name: _____ Phone: _____ Address: _____ Fax: _____ City: _____ State: _____ Zip: _____
Counseling & Psychological Services Information to be Released (Check all appropriate boxes)	☐ Evaluations & Progress Notes ☐ Verification of Treatment ☐ Entire Counseling Records ☐ Records Dated: _____
Health & Psychiatric Services Information to be Released (Check all appropriate boxes)	☐ Entire Health Record ☐ Psychiatric Notes ☐ Immunization Records ☐ X-Ray Reports ☐ Lab Reports/Test ☐ Records Dated: _____

Method of Delivery:

☐ Secure Email ☐ FAX ☐ Paper/Mail ☐ No Records to be sent (Documentation/Phone consultation

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- This authorization may be canceled (revoked) in writing at any time. A cancelation will not change releases that happened before the cancelation was submitted.
- Student Health & Counseling Services (SHCS) records may include records that it received from other organizations. If these records have been used by SHCS and filed in the record SHCS maintains about you, these records may be released with your SHCS records.
- SHCS cannot prevent disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release SHCS from any and all liability resulting from a disclosure by the release.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____
Signature (Patient/Client) Date

_____ _____
Signature (Parent/Guardian) If Applicable Date