PO Box 7000, Azusa, CA 91702
(626) 815-2100; Fax (626) 815-2102

Student Health Center

Authorization to Disclose Medical Records

RECORDS FROM:

I authorize ____ to release a copy of the medical record for
(Print name of Health Care Provider)

____ ________________________
(Print Patient Name) (Date of Birth)

RECORDS TO: (Print Name, address, and fax number of Recipient)

____

____

FOR THE PURPOSE OF: ____

By checking at least one of the lines below (at least one line must be checked in order for the form to be valid), I authorize the release of my medical records to be used in a specific and meaningful fashion.

___ Records of my treatment for dates beginning ____________________ and ending on __________________
(The patient agrees to pay all reasonable charges associated with providing this record.)

___ Lab reports
___ X-ray/imaging reports
___ Other: _________________________________
___ Immunization records
___ Mental health information (must initial)
___ TB skin test result

I HEREBY LIMIT THE AUTHORIZATION ACCORDING TO THE FOLLOWING:

___ This authorization is limited to the following treatment(s):

____

___ This authorization is limited to the following time period: ____

This authorization may be revoked by written notice at any time but would not take effect until it is received by our office. Any information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by this rule. You do have the right to refuse to sign this authorization without your treatment being affected or any financial repercussions. Unless revoked earlier, this consent will expire one year from the date of signing or shall remain in effect for the period of time to reasonably complete the request. I understand that I may receive a copy of this authorization.

______________ ____
Date signed Signature of Patient or Person Authorized by Law

______________ ____
Date signed Witness