California State University
SAN MARCOS

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please read carefully and complete all sections included in this document.

Patient Name: _____ Date of Birth: _____

Student ID #: _____ Phone #: _____

Information to be Released *(Check all that apply)*	**For dates of service:** From: _____/_____/_____ To:_____/_____/_____ Month Day Year Month Day Year ☐ **Progress/Office Notes** ☐ **GYN/Pap Smear Records** ☐ **Laboratory Tests** ☐ **Radiology Reports** ☐ **Immunization Records** ☐ **TB Test Records/Risk Assessment** ☐ **Other** *(please specify)*:_____
Sensitive Information *(special authorization required)*	**Sensitive information <u>WILL NOT BE RELEASED</u> unless you <u>initial</u> below:** _____ Release Psychiatric Treatment Records _____ Release HIV/AIDS Test Results From: _____/_____/_____ To:_____/_____/_____ Month Day Year Month Day Year

I hereby authorize and request that:

☐ **<u>Option 1:</u> SHCS release patient records to:**	☐ **<u>Option 2:</u> SHCS obtain a copy of records from:**	☐ **<u>Option 3:</u> SHCS provider to verbally communicate protected health information with:**
Name of Facility/Provider/Person: _____ _____ Address: _____ City/State/Zip Code: _____ Phone Number: _____ Fax Number: : _____ Preferred Method for Delivery: ☐ Mail ☐ Fax ☐ Pick-Up ☐ Email: _____	Name of Facility/Provider/Person: _____ _____ Address: _____ City/State/Zip Code: _____ Phone Number: _____ Fax Number: : _____ Preferred Method for Delivery: ☐ Mail ☐ Fax	Name of Facility/Provider/Person: _____ _____ Address: _____ City/State/Zip Code: _____ Phone Number: _____ Relation to Patient: _____

Authorization: I understand this authorization is voluntary and authorizes the use or disclosure of Protected Health Information (PHI) in the manner described below. This authorization is requested to comply with the Health Insurance Portability and Accountability Act (HIPAA) when disclosing PHI. Be aware that once the patient's information leaves Student Health & Counseling Services (SHCS), we are no longer able to protect that information and the recipients of your information may not be legally required to protect your information.
By signing this document, the patient also hereby releases SHCS from any/all liability that may arise from the release of this information to the party named below.

Authorization to Disclose Sensitive Protected Health Information: Federal and State laws require SHCS to obtain specific authorization from patients to release sensitive information. Sensitive information is defined as treatment or documentation related to psychiatric, HIV and AIDS test results, drug, and/or alcohol related records. Be aware that SHCS will try to exclude these types of information unless you specifically identify them for release.

Revocation/Duration: I understand that I may revoke this authorization in writing at any time, except to the extent that the action has already been taken. Unless otherwise revoked, this authorization will **expire one year** from the date of signature below.

By signing below, I acknowledge I have read, understand, and agree to the terms listed on pages 1 and 2 of this authorization.

_____	_____	_____
Signature of Patient or Authorized Representative	**Print Name**	**Date** (MM/DD/YY)

Relationship (*if signed by other than patient*): _____

OFFICE USE ONLY	ID Verified By: _____ Patient will pick up approx. on: _____ ☐ Emailed (date/time)_____ ☐ Mailed (date/time)_____ ☐ Faxed (date/time)_____ ☐ Picked Up (date/time)_____ Payment Amount:$_____ Debit / Cash *(if applicable, circle payment method received)* ☐ Documents Released/Comments: _____

Revised 01/2023