AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name (Print Full Name):_____

Date of Birth: _____

CSUN ID Number:_____

Phone Number:_____

Email Address:_____

ACKNOWLEDGEMENT

I authorize the use or disclosure of my health information as described below by the Klotz Student Health Center, California State University Northridge, 18111 Nordhoff Street, Northridge, CA 91330-8270. Phone (818) 677-3666; Fax (818) 677-2304. ***Please note: It is not permissible to alter this form. If altered, this could result in reporting to the CSUN's Student Conduct office and will delay the processing of your request.***

A picture ID (or a copy of the picture ID) is required to release any information.

1. FORMAT OF RECORD

☐ Hard Copy
☐ Flash Drive ($5 Charge)
☐ Fax Number: _____

Note: We do not release or disclose medical records via email.

2. RECIPIENT INFORMATION

The information authorized above may be disclosed to and used by the following individual or organization:

Recipient Name or Entity: _____

Recipient Street Address: _____

Recipient City, State, and Zip Code/Postal Code: _____

3. AUTHORIZATION TO RELEASE/DISCLOSE MEDICAL RECORDS

Please complete this section indicating what records are to be released and/or disclosed. The first ten pages are free, each additional page is $0.10. Lab and x-ray results cannot be released until the provider has reviewed the results with the patient. Copies are provided within fifteen (15) days after receipt of this written request.

☐ Consultation Reports/Clinic Notes from _____ to _____
☐ Immunization Record
☐ Most Recent Glasses/Contact Lens Prescription
☐ Laboratory results from _____ to _____
☐ X-ray and Imaging Reports from _____ to _____
☐ Most recent history and physical
☐ Entire Medical Record
☐ HIV Test Results
☐ Other: _____

PSYCHOTHERAPY RECORDS

I understand that the information in my health record may also include information about behavioral or mental health services, and that if I wish to have psychotherapy records disclosed, I must sign a *separate written authorization* that complies with California Civil Code § 56.10 and, if applicable, § 56.104. ***A general authorization for the release of medical or other information is NOT in all cases sufficient for this purpose.***

ALCOHOL & DRUG TREATMENT RECORDS

I understand that the information in my health record may also include information about treatment for alcohol and drug abuse, and that if I wish to have such records disclosed, I must sign a **separate written authorization** that complies with federal law (including C.F.R. 42 U.S.C. § 290dd-2 and Part 2). A general authorization for the release of medical or other information is ***NOT*** sufficient for this purpose.

4. OPTIONAL: REVOCATION, DURATION & REDISCLOSURE

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 and present my written revocation to the Health Information Management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date:_____(If I fail to specify an expiration date, event or condition, this authorization will expire automatically in 90 days)

5. SIGNATURE

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment at the SHC. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 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 Ederlina Landeta, Interim Student Health Center Director, at 818-677-3660. I understand that I am entitled to receive a copy of this authorization.

_____
Signature of Patient or Legal Representative

_____
If Signed by Legal Representative, Relationship to Patient

_____
Date

_____
Signature of Witness