NAME (PRINT): ____

ID NUMBER: ____________________________

Date of Birth: ____________________________

Phone Number(s)/E-mail Address: ____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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.

Picture ID is required to release any information. Please complete the 6 steps.

1. FORMAT OF RECORD

☐ Hard Copy Electronic Media (CD/Flash Drive) $5 Fax #: ____________________

Note: We do not accept e-mail requests.

2. RECIPIENT

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

Please complete this section indicating what records to be released and/or disclosed. First ten print 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

☐ Other: ____

4. OPTIONAL:

☐ HIV Test Results

____ __________________________

Signature of Patient or Patient's Representative Date

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 <u>separate written authorization</u> 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 <u>separate written authorization</u> 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.***

5. 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)

6. 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, Assistant 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