



# CALIFORNIA STATE UNIVERSITY, FULLERTON

Division of Student Affairs  
Student Health & Counseling Center  
P.O. Box 6830, Fullerton, CA 92834-6830  
(657)278-2810 Fax (657)278-3069

## Authorization for Disclosure and Release of Medical Information

This Authorization for disclosure and release of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56 et. Seq., of the California Civil Code, the Health and Safety Code, Section 199.21 (g) and the Lanterman-Petris-Short Act, alcohol and drug abuse regulation, Welfare and Institutions Code Section 5328.7

I Authorize CSUF Student Health and Counseling Center to release information as specified below from my records to:

Name: \_\_\_\_\_ (Doctor, Ins. Agent, Self)

Address: \_\_\_\_\_

I understand this is not a secure line. \_\_\_\_\_

Fax # \_\_\_\_\_ Office # \_\_\_\_\_

For the Purpose of: \_\_\_\_\_

Specific Illness, injury and dates requested

\_\_\_\_\_

This authorization is limited to the following information:

- Physical Exam       X-ray Report       Physical Therapy Report
- Lab Reports (Pap)       Progress Notes       Drug&Alcohol Use
- HIV/AIDS Test       Immunizations (MMR/HepB/TBTest)
- Other (Please Specify)
- Complete Medical Records

Duration: This Authorization is Valid from \_\_\_\_\_ to \_\_\_\_\_.

I understand I have a right to receive a copy of this authorization upon my request. Copy Requested:  Yes  No Copy received:  Yes  No

I understand that the request may not further be used to disclose medical information unless authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ I.D. # \_\_\_\_\_

Address: \_\_\_\_\_

Phone# \_\_\_\_\_ Witnessed by: \_\_\_\_\_

**Correspondence requests**

To \_\_\_\_\_ Date \_\_\_\_\_

Re \_\_\_\_\_ **Medical Record#** \_\_\_\_\_

Copies of the records requested may not be released without charge.

Charges are: \$ 2.50 (1-5 pages)

Additional pages x \$ 0.50 per page

**Total Pages** \_\_\_\_\_

**Total Charges** \_\_\_\_\_

Checks should be made payable to **CSUF Health Center**. Please include on your check the patient's name as well as their student I.D Number.

Please be advised that we may have to get prior approval from provider if results have not been discussed with you.

It is our policy not to accept subpoenas by mail. Any subpoena must be served in person and delivered to the Vice President of Student Affairs.

Particular diagnoses are protected by specific laws, which may require a different authorization form.

**For Medical Records Department use only**

Chart reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Authorization to be released  Yes  No

Copied by: \_\_\_\_\_

Faxed  Hand carried  Mailed

Date: \_\_\_\_\_