CSUF | TitanMED STUDENT AFFAIRS

800 N. State College Blvd., Fullerton, CA 92831-6830
T: 657-278-2800 | F: 657-278-3069
Email request to: healthrecordsrequest@fullerton.edu

Authorization for the Release or Request of Clinical Information

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip:_____
Phone: _____CWID: _____

I Authorize CSUF TitanMED to: *(choose one)*

_____Release my private health information to
_____Request my private health information from
Name: _____
Address: _____ City: _____ State: _____ Zip:____
Phone:_____ Fax: _____ (maximum 5 pages)

DURATION: Authorization shall remain in effect for 6 months from the date of signature below.

This authorization is limited to the following information only:

- ☐ Complete Records
- ☐ Immunization Records
- ☐ Chiropractic Records
- ☐ HIV Result/PREP/PEP _____ (initial)
- ☐ Billing (dates of service) _____
- ☐ Gender Affirming Care _____ (initial)
- ☐ Physical Therapy Notes
- ☐ Lab/Pathology _____
- ☐ X-Ray Report ☐ X-Ray Film
- ☐ Alcohol/Drug Treatment _____ (initial)
- ☐ Reproductive Health Records
- ☐ Other _____

Records are being disclosed for the following purpose:

☐ Continuing Care ☐ Personal Records ☐Other: _____

Records will be:

☐ Picked Up ☐ Faxed ☐ Certified Mail ☐ Titan Health Portal *(not all records can be placed on the portal)*

This Authorization for disclosure and release of medical information is being requested by 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 understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand this authorization is voluntary.
- I understand that I or my personal representative may revoke this authorization for future disclosures by submitting a written request to CSUF TitanMED. Revocation will not apply to information that has already been disclosed prior to receipt of the written request. [45 C.F.R.

§164.508(c)(2)(i)]

- The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization [45 C.F.R. § 164.508(c)(2)(ii)(A)]
- Under California Civil Code [Civil Code §56.13] , the recipient of the protected health information ,who received it with authorization, may not further disclose that information except with a new authorization or as specifically permitted by other laws
- I understand that there is potential for information disclosed under the terms of the authorization to be redisclosed by the recipient and no longer protected by federal confidentiality rules [45 C.F.R. §164.508(c)(2)(iii)]
- I have the right to receive a copy of this authorization. [Civil Code § 56.11(b)(9)]
- Reasonable fees may be charged to cover the cost of copying and postage related to releasing this protected health information. [45 C.F.R. § 164.524(c)(2)(iii)(B) & California Health and Safety Code §123110(a)]
- Please be advised that, if your results have not yet been discussed with you, prior approval from a provider may be required before your records are released.

Signature of Patient: _____ Date: _____
Signature of Patient Representative: _____ Date: _____
Relationship to Patient: _____
Description of the authority to act on behalf of the patient: _____

You can access and print most of your medical records through your TitanHEALTH Portal

You may submit your request by email healthrecordsrequest@fullerton.edu, fax (657)278-3069, in person, or by mail.

Records will be provided on a USB drive. A $5 fee will apply.

Charges for records will be posted to your student account within 48 hours. Once posted, payment may be made by going Online via your CSUF Student Portal, in person at Gordon Hall 180, or by contacting Student Business Services at (657) 278-4295 for additional payment options.

By completing this release, I am aware of the possibility of a charge for a copy of my medical records.

For Medical Records Department Use Only

Total Pages:_____ Charge:____ Disclosed by: ____Paper ____USB ____ Fax

Records prepared by: _____ Date: _____

Records picked up on: _____ Records delivered by: _____