CSUF | TitanMED STUDENT AFFAIRS
800 N. State College Blvd., Fullerton, CA 92831-6830
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Authorization for the Release or Request of Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____City: _____State: _____Zip:_____

Telephone #: _____CWID: _____

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

___Release my private health information to

___Request my private health information from

Name: _____

Address: _____

Phone#: _____Fax#: _____(maximum 5 pages)

This authorization will expire on _____or 90 days from the date signed.

This authorization is limited to the following information only:

- ☐ Complete Records
- ☐ Immunization Records
- ☐ Chiropractic Records
- ☐ HIV Result/PREP/PEP _____ (initial)
- ☐ Billing (dates of service) _____
- ☐ Physical Therapy Notes
- ☐ Lab/Pathology _____
- ☐ X-Ray Report ☐ X-Ray Film
- ☐ Alcohol/Drug Abuse
- ☐ 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 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 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 reserve the right to revoke this authorization in writing, at any time to CSUF's Student Wellness. The authorization will stop further release of my protected

health information on the date my valid revocation request is received by Student Wellness. [45 C.F.R. §164.508(c)(2)(ii)]

- I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]
- Under California law, the recipient of the protected health information under the authorization is prohibited from redisclosing the protected health information, except with a written authorization or as specially required or permitted by law [Civil Code § 56.13]
- If the organization or personal have authorized to receive the protected health information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations. [45 C.F.R. § 164.524(a)(2)(v)]
- I have the right to receive a copy of this authorization. [45 C.F.R. § 164.508(c)(4) & Civ Code § 56.11(i)]
- 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)(4) et seq. & California Health and Safety Code §123110, et seq.]
- Please be advised that we may have to get prior approval from a provider if your results have not yet been discussed with you, before releasing your records.

Signature of Patient: _____Date: _____

Charges for records will post to your student account within 48 hours. At that time, you may make a payment online via your Titan Online Student Center, in person at GH-180 Window 6 or contact Student Business Services at (657)278-4295 for other payment options.
Any records exceeding 5 pages will be put on a USB
Charges will be assessed after preparation of records
Records on USB: $5 X-Ray Film on Disc: $5

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

For Medical Records Department Use Only

Total Pages:_____

Total Charge:_____

Disclosed by: ___Paper ___USB ___Fax ___Titan Health Portal (*not all records can be placed on the portal*)

Records prepared by: _____Date: _____

Records picked up on: _____*Records delivered by:* _____