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 my private health information as specified below to:

Name: _____ (Doctor, Ins. Agent, Self)
Address: _____
_____

Fax#: _____ Office#: _____
I understand that this is not a secure line. _____ (initial ***only*** if information is to be faxed, up to 5 pages)

Specific illness, injury and dates requested

_____

This authorization is limited to the following information only:

___ Physical Exam ___ X-ray Report / Film ___ Physical Therapy Notes

___ Lab Reports ___ Progress Notes ___ Drug and Alcohol Use

___ HIV / AIDS Results ___ Immunization (MMR / Hep B / TB Test, etc.)

___ Pap Smear Results ___ Complete Medical Records

___ Other, please specify: _____

Duration: This authorization is valid from _____ to _____(not to exceed 3 months)

- I understand that I have the right to receive a copy of this authorization upon my request.
- I understand that I may not be required to sign this authorization as a condition to obtain treatment or obtain my eligibility benefits.
- I also understand that I may revoke this authorization in writing at anytime by sending a notice to the custodian of records. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this authorization.
- I understand that the CSUF Health Center is required to keep my health information confidential, and re-disclosure of my health information without my authorization is prohibited by state and federal law.

- I further understand that the potential exists for re-disclosure of my private health information and it may no longer be protected under HIPAA, if I choose to disclose my private health information to someone who is not legally required to keep it confidential.
- I also understand that I am entitled to receive notice if my protected health information has been breached.

Signature of Patient: _____ Date: _____

Print Name: _____ CWID#: _____

Address: _____

DOB: _____ Phone#: _____ Witnessed by: _____

The Student Health Center accepts **cash**, **check**, **credit card** or **Titan Tender** as a form of payment. Checks should be made payable to CSUF Health Center. Please include your CWID number on your check.

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.

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 located at LH 805.

Particular diagnoses are protected by specific laws, which may require a different authorization form.
Copies of records may *not* be released without charge.
Charges are:
Paper: $.25 each page
X-ray Film or CD: $5.00

I would ***not* like to receive my PHI on CD _____**

I have read the above statement and am aware of the possibility of a charge for a copy of my medical records. ____

For Medical Records Department Use Only

___ Fax ___ Mail ___ Pick Up _____

Total Pages: _____
Total Charge: _____

Chart reviewed by: _____ Date: _____
Copied by: _____

___ Fax ___ Certified mail ___ Hand carried from cashier
Date: _____