



SAN DIEGO STATE UNIVERSITY

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize SDSU Student Health Services \*TO RELEASE MY RECORDS TO: (location where records are to be sent)

Name: \_\_\_\_\_

Phone # \_\_\_\_\_

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

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

City, State, Zip: \_\_\_\_\_

Attn: \_\_\_\_\_

\*RECORDS TO BE RELEASED:

- Progress Notes
Laboratory Tests
X-Ray Reports
GYN/ Pap Smear Records
Immunization Records

- HIV Test Results (initial)
Psychiatric Records (initial)
TB Test Records
Itemized Billing Statement

Other: (Please Specify) \_\_\_\_\_

\*PURPOSE OF DISCLOSURE:

- Continuing Medical Care
Insurance

- Personal Use
Other: \_\_\_\_\_

\*PATIENT INFORMATION: (your information)

Name: \_\_\_\_\_

D.O.B \_\_\_\_\_

Red ID # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Phone # \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

\*This authorization is valid from \_\_\_\_\_ to \_\_\_\_\_ (Date) (Date)

If no valid date, this authorization will be valid for 180 days. Signer may revoke this consent at any time in writing and will be effective upon receipt. I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Signature of Patient or authorized person

Date

Signature of Witness

Date