Authorization for Release of Medical Information

Sonoma State University Student Health Center

1801 East Cotati Ave., Rohnert Park, CA 94928 ** Phone: 707 664-2921 ** Fax: 707 664-2925

I authorize the release of information from my medical records only as specified below. I understand that:

1) This authorization will expire three months from the date signed or earlier upon my written revocation.
2) Expiration or cancellation doesn't apply to records sent prior to expiration or receipt of my revocation.
3) I am entitled to a copy of this authorization.

Patient's Full Name (list other names used)**:** ____

Student ID Number ______________________ **Date of Birth** ____________ **Phone**: (___) _______________________

Records to be Released From: (Disclosing Party)

Name of Organization &/or Clinical Provider: ____

Phone: (____)___________________________ **FAX:** (____)__________________________

Address: **Street:** ____

City: _______________________________________**State:** _____________ **Zip:** ___________________

Records to be Released To: (Recipient)

Name of Organization &/or Clinical Provider: ____

Phone: (____)_________________________ **FAX:** (____)______________________________

Address: **Street:** ____

City: ____**State:** ____________ **Zip:** __________________

For the Following Purpose: ____

Specify Medical Information to be Released:

☐ Pap Smear reports **ONLY** (Dates): ________________________ ☐ Immunization records **ONLY:** ____________________

☐ Medical records: (Indicate Applicable Dates): ____

☐ Lab reports: ☐ X-ray reports: (Type of Test & Date): ____

☐ Records pertaining only to: ____

Release of the Following Medical Information Requires Additional Authorization (Specify & initial below.)

☐ Drug &/or Alcohol Information: **Patient's Signature:** ________________

☐ Mental Health /Developmental Disability: **Patient's Signature:** ________________

☐ HIV Test Results/Disease: **Patient's Signature:** ________________

Limitations: Disclosure of SSU Student Health Center Medical Records information is for medical treatment purposes only. In accordance with the **Family Educational Rights and Privacy Act (FERPA)** further disclosure is of this health information by the recipient to other individuals or entities is not permitted.

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Signature of Patient: ____ **Date:**___________

Signature of Witness: ____ **Date:**___________

Upon the patient's written authorization, the SSU Student Health Center will release medically necessary records to a medical provider or organization by mail for medical treatment purposes. A charge will apply for records requested for legal or business purposes, for the patient's personal use, or by individuals no longer enrolled at SSU.