California State Polytechnic University, Pomona - Student Health and Wellness Services
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AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please **REQUEST** Medical Information **FROM:**

_____
Name of Health Care Provider

_____
Name of Medical Office/ Hospital

_____
Street Address

_____
City, State, and Zip Code

Please **SEND** Medical Information **To:**

_____
Name of Person or Entity to Receive Information

_____
Title (Physician, Therapist, Attorney, Insurance Co.)

_____
Street Address

_____
City, State, and Zip Code

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health provider, entity, or person I have indicated above. Release and/or disclose records and information regarding:

_____ _____ _____
Name of Patient (List Other Names Used) BroncoNumber Date of Birth

_____
Address City/State/Zip Code Telephone Number

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (3 months) from date of signature.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Re-disclosure: 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.

Specify records to be released and/or disclosed: Initial which type of information is to be released and /or disclosed:

__ **General Medical Information** (from____to____) **Information Regarding Specific Injury/Treatment** _____

__ **X-Ray (check one or both):** Films____ Reports____ **Laboratory Result** _____

__ **Mental Health** (from____ to____) _____
Signature of Patient or Patient's Representative Date

__ **Alcohol/Drug** (from____ to____) _____
Signature of Patient or Patient's Representative Date

__ **HIV Test Results** (from____ to____) _____
Signature of Patient or Patient's Representative Date

__ **Other (specify)** _____

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purposes only:

_____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep.

_____
Date Signature of Patient or Patient's Representative Indicate Relationship (If signed by Other than Patient)