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