

Authorization for use and/or disclosure of patient health information

I understand that Cowell Student Health Center will not condition treatment, payment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize:

Name of disclosing party

Address

Tele #:

Fax #:

to disclose to:

Cowell Student Health Center
Santa Clara University
500 El Camino Real
Santa Clara, CA 95053
T: 408-554-4501 F: 408-554-2376

Records and
information
pertaining to:

Patient name

Date of birth

Address

Telephone number

Duration: This authorization shall become effective immediately and shall be in effect for one year from the date of signature unless a different date is specified here _____.

Revocation: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

We are requesting the following medical information:

Please specify records by checking the box and initial to specify which type of information is to be disclosed.

- Emergency room records
- Transcribed hospital records
- Laboratory reports
- Consultation reports
- Xray/Imaging reports
- Clinician office chart notes
- Immunization records
- Operative reports

Related to: _____

Other: _____

Requests for the following types of information require signature for each:

Psychiatric/Mental Health	HIV test results	
_____	_____	
Signature/Date	Signature/Date	

The recipient may use the health information authorized on this form for the following purposes: _____

Patient Signature

____/____/_____
Date

Print Name