

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
STUDENT HEALTH CENTER
RELEASE OF MEDICAL RECORDS

PLEASE PRINT:

Last Name	First Name	M.I.	Date of Birth
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COMPLETE ADDRESS

I, the undersigned, hereby authorize the:
Student Health Center at Cal State University, San Bernardino

Please check this box if you would like a CD copy of your medical records (\$5 charge for CD)

To release or disclose the following records, mark all that apply:

- General medical information (from _____ to _____)
- X-ray Results Dated _____ Laboratory Results Dated _____
- Last Pap and Progress notes _____ Immunizations _____
- Other/All Records _____

Allow 7-10 days for processing

I understand that the information in my medical record may include information relating to sexually transmitted disease, AIDS, or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, & treatment for alcohol and drug abuse. *PLEASE INITIAL _____

*Please release records by mail or Fax to: (Specify Name, Address, Zip Code and Fax # if applicable)

_____ Please Note: We DO NOT fax entire charts.

_____ FAX #: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until
(_____ (enter date) or for one year from the date of signature if not date entered.

REVOCACTION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the SHC. Written revocation will not affect any action specifically required or taken in advance of this authorization before the written revocation was received.

REDISCLASURE: I understand that the requester may not lawfully further use of disclose the health information unless another authorization is obtained from me or unless disclosure is permitted by law.

Student Signature

Student ID #

Date: _____

Witness Signature

OFFICE USE ONLY:

Date mailed _____ Faxed _____ Given to student _____ Left at front office for pick-up _____

Completed by: _____ Date: _____ Verified by: _____ Date: _____