CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

Student Health Center

CSUSB Student Health Center (SHC)
5500 University Pkwy, San Bernardino, CA 92407
(909) 537-5241 [phone] (909) 537-7027 [fax]

AUTHORIZATION FOR RELEASE OR EXCHANGE OF HEALTH INFORMATION

Name _____ Date of Birth _____ CSUSB ID# _____

I voluntarily authorize CSUSB Student Health Center to:

☐ **Exchange** my Health Information (including counseling and medical information) among treatment professionals within the **SHC** and **Counseling and Psychological Services (CAPS)** to coordinate my care.

☐ **Release** to, ☐ **Exchange** with or, ☐ **Request** from the recipient identified below my health information:

_____
Person, provider, or agency

_____
Street

_____
City, State, Zip Code

_____ _____
Telephone Fax Number

Type of Disclosure: ☐ Verbal Information ☐ Letter/Treatment Summary ☐ Copy of Records

Specific Authorizations:

I specifically authorize the release of the following information by **checking** the relevant box(es) below:

- ☐ Mental health information, diagnosis and treatment
- ☐ Medical information, diagnosis and treatment
- ☐ Drug and alcohol abuse information, diagnosis or treatment
- ☐ HIV/AIDS testing information
- ☐ Correspondence and records from my other health care providers that the above-named health care providers may hold
- ☐ Disclosure will be limited to: _____

Purpose of Release:

I understand that the specific purpose of this Authorization is:

□ Coordination of treatment

□ Other (*state reason*) _____

□ Documentation to support university appeals.

This authorization is limited to only that information that I have requested to be used or disclosed to the persons/facilities named herein. I hereby release SHC and its employees from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information pursuant to this authorization.

Terms:

I understand that:

Use: this health information may be used by the person I authorize to receive it for evaluation, treatment and/or consultation, or other purposes as I may direct.

Expiration: unless I revoke this authorization in writing earlier, it will automatically expire one year from the date it is signed, unless indicated here *(Please specify, if necessary):*_____.

Re-Disclosure: once the requested information is disclosed pursuant to this authorization, SHC will no longer have control over the information. There is a potential that it may be re-disclosed by the recipient and may no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

Refusal to Sign: SHC cannot require me to sign this authorization as a condition to the provision of services.

Revocation: I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about the information already used or disclosed under this authorization.

Copy: I can receive a copy of this completed form upon request.

Document: A photocopy, fax, or electronic copy of this authorization shall be considered as effective and as valid as the original.

Certification: I certify that I am (*check whichever applies*):

□ The client and the information and identification I have provided is true and correct.

□ The client's authorized representative, and the identification and proof of authority I have provided are true and correct. My relationship to the client is: _____.

_____	_____	_____
Client or Representative (print)	*Signature*	*Date*
_____	_____	_____
Witness (print)	*Signature*	*Date*