CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
STUDENT HEALTH CENTER
(909) 537-5241

REQUEST FOR MEDICAL RECORDS

PLEASE PRINT

Last Name First Name M.I. Date of Birth

Complete Address

I, the undersigned, hereby authorize: (Specify Name, Address, Zip Code and fax number if applicable)

If Faxed, Faxed Copy is Valid as an Original.

Fax No.

to provide the following records pertaining to my health (please be specific):

Please release records by mail or Fax to:

California State University, San Bernardino
Student Health Center
5500 University Parkway
San Bernardino, California 92407
FAX: (909) 537-7027

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 no date entered.

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

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 permitted by law.

Student Signature Student ID #

Date:

Witness

OFFICE USE ONLY:

Date mailed / faxed (circle one) Please initial completed by:____________

Req for MR Revised 11/08erb