CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
STUDENT HEALTH CENTER

RELEASE OF MEDICAL RECORDS

PLEASE PRINT:

Last Name	**First Name**	**M.I.**	**Date of Birth**

COMPLETE ADDRESS

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

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.**

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____ **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.

REVOCATION: 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.

REDISCLOSURE: 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:

___ Certified Mail
___ Faxed
___ Ready for pick-up
___ Given to Patient

Completed by: ____________________ Date: __________ Verified by: ____________________ Date: __________