SDSU San Diego State University

Mailing Address: San Diego State University, Student Health Services
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Information: *Please list your information*	**Patient Name (First, MI, Last)**		**Nickname/Maiden/Other**
	Address/City/State/Zip		
	Date of Birth (MM/DD/YY)	**Phone**	**ID #**
	_____ /_____ / _____		
Record Holder: *Who has the information you want released?*	□ **SDSU Student Health Services** □ **Other:** _____		
	Address/City/State/Zip		
	Phone	**Fax**	**Email***
Release Records to: *Where do you want records sent? Who do you want to receive records?*	**Name of Hospital/Clinic/University/Person/Self**		
	Street Address/City/State/Zip		
	Phone	**Fax**	**Email***
Purpose: *What is the reason for your request?*	□ Continued Care □ Personal Use □ Insurance □ Employment Purpose □ Other (*please specify*): _____		
Delivery Method:	Please select **one**: □ Mail □ Pick-up □ Fax □ HealtheConnect □ Email* If Email*: □ Secured □ Unsecured		
Health Information to be Released: *What information do you want sent or released?*	□ **Progress Notes** □ **Laboratory Tests** □ **TB Test Records** □ **Immunization Records**	□ **GYN/Pap Smear Records** □ **X-Ray Reports** □ **Radiology Images (only) on:** □ **CD** □ **USB** □ **Electronically **See NOTE**	
	□ **Other** (*please specify*): _____		

Sensitive Information:	**Sensitive Information <u>WILL NOT BE RELEASED</u> unless you initial below:** _____ Release Mental Health/Psychiatric treatment records _____ Release HIV Test Results _____ Release Drug & Alcohol treatment records

By signing below I authorize the disclosure of my protected health information as outlined above. I understand I can revoke this consent at any time in writing and it will be effective upon receipt, except to the extent action has already been taken in reliance on this authorization. This authorization is valid for a one-time disclosure that will occur upon receipt of a complete and valid authorization form. Requests for additional disclosures must be requested with a new form. I recognize that I have the right to a copy of this completed authorization. I have read and understand this form in its entirety.

_____	_____	_____
Signature of Patient or Authorized Representative	**Print Name**	**Date**

***Receiving/Transmitting Records Electronically:** I understand that if I select unsecured transmission of records via email, there is some risk that protected health information or other confidential information being released may be misdirected, read, or intercepted by unauthorized parties.
****NOTE**: due to image size, radiology images may be too large to transmit via email.

Notice: San Diego State University Student Health Services is required by law to keep your health information confidential, as are many other organizations and individuals such as hospitals, medical providers, and health (insurance) plans. Please be aware that once your information is released, SDSU Student Health Services is no longer able to protect that information and recipients of your information may not be legally required to protect your information.

SHS Staff Use Only: *Staff Name:* _____	Description of Records Released:
	Released To:
	Distribution Method:
	Date of Release: