FRESNO STATE
Student Health and Counseling Center
5044 N. Barton Ave. MS HC81 • Fresno, CA 93740
Phone: 559.278.2734 • Fax: 559.278.7602

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Instructions: The patient must complete this form for the Student Health and Counseling Center to release or request any medical information. Please be specific as to the nature of the information to be released.

I Authorize: ☐ The Student Health and Counseling Center

OR ☐ (Name of Individual or Agency) _____

(Complete Address) _____

(City, State, Zip) _____

(Phone Number) _____

To Release the Following: (Please check those that apply)

☐ Entire Chart
☐ All records for my treatment for dates beginning _____ & ending on_____
☐ Lab reports dated_____
☐ X-Ray reports/films (circle one) dated_____
☐ Immunizations only (Please specify) _____
_____ (initial) ☐ HIV test results [ ] Pregnancy test results [ ] STI test results [ ] Substance Abuse
_____ (initial) ☐ Psychiatry Notes [ ] Counseling Notes
☐ Other _____

Release To: ☐ California State University, Fresno
Student Health and Counseling Center
5044 N. Barton Ave. MS HC81
Fresno, CA 93740
Phone: 559.278.2734
Fax: 559.278.7602

☐ _____
_____
_____
_____

For the purpose of: _____

This information is for the use by the above named recipient only. It cannot be given to another individual or agency without the patient's consent. This authorization will expire in two months from the date below, or on _____. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164-.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure of the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Student Health and Counseling Center Medical Records Supervisor.

Patient Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Purpose of Copies: _____ Fresno State ID#: _____

FOR OFFICE USE ONLY:

Approved: _____
Patient to pick up on: _____

Records Mailed: ____/____/____ By: _____
Hand Carried: ____/____/____ By: _____
Records Faxed: ____/____/____ By: _____
Refuse Release: ____/____/____ By: _____

Remarks: _____