CALIFORNIA STATE UNIVERSITY, FRESNO
Student Health and Counseling Center
5044 N. Barton Ave. MS –HC81 Phone: 559-278-2734
Fresno, CA 93740 Fax: 559-278-7602

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Instructions: The patient must complete this form in its entirety in order for the Health Center to release or request any medical information. Please be specific as to the nature of the information to be released.

I Authorize: ☐ 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
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☐ _____

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 CSUF University Health & Psychological Services Medical Records Supervisor.

Patient Signature: _____ Date: _____

Printed Name: _____ Date of Birth_____

Purpose of copies_____ CSUF ID#_____

FOR OFFICE USE ONLY:

Approved: _____
Patient to pick up on: _____

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

Requesting Provider: _____
Remarks: _____

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PERMISSION FOR VERBAL COMMUNICATIONS

_____ _____
(Print name of patient) (Date of Birth)

_____ _____
(Street address) (Student ID#)

_____ _____
(City, State, Zip Code) (Phone number)

I permit Student Health and Counseling Center, their physicians, nurses and other personal ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care:

	Name	**Phone Number**	**Relationship**
1	_____	_____	_____
2	_____	_____	_____

This authorization is limited to discussions regarding the following medical condition(s):

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following timeframe from _____ to _____.
(If no dates are indicated, this authorization will expire 14 days from below).

If, at any time, I do not want verbal discussion to be permitted between my health care providers and any of the individual named above, I must notify my health care provider by contacting the Student Health and Counseling Center Medical Record Department.

Patient Signature:_____ Date: _____

FOR OFFICE USE ONLY:

Approved By: _____ Date:_____