

This form to be completed by patient.

I hereby authorize the Student Health Center at California State University, Los Angeles to release the following information.

The reason for which the information may be used is:

- Medical Education Personal
 Employment Legal Other (state)_____

This authorization is valid for the following length of time_____

Release the following:

Medical Records pertaining to my_____ on or about_____ (Illness) (Date)

Mental Health Records_____ (Clearly specify records to be released)

Physical examination taken on_____

X-ray films and/or report of_____ taken on or about_____

Laboratory tests_____

Other_____

Mail Hand Carry Fax Number:(_____)_____ above-stated medical records to:

Name_____

Address_____

City_____ State_____ Zip_____

Patient Information:

Print Name_____ Signature_____

Address_____ City_____ State_____ Zip_____

Date_____ Telephone No. (_____)_____ CIN _____ - _____ - _____

It is the policy of the Student Health Center to provide general medical records pursuant to a general authorization. Records relating to mental health, substance abuse issues and HIV testing require separate authorizations. This information is intended solely for the use of the individual or entity to which it is addressed and is privileged, confidential and exempt from disclosure under applicable law.

A copy of this authorization will be provided to the patient upon request.

Do not write below this line

Given to Patient Mailed Fax'd Date_____ By:_____

common/forms/med-rec/release/10-08



California State University, Los Angeles
STUDENT HEALTH CENTER

RELEASE OF MEDICAL INFORMATION

Last Name_____
First_____
CIN _____