

THIS FORM TO BE COMPLETED BY PATIENT

I hereby authorize: Name _____
Address _____
City/State/Zip _____

to release the information listed below.

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 _____

The purpose 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 _____

Mail to:

Student Health Center
California State University, Los Angeles
5151 State University Drive
Los Angeles, CA 90032-8411
Attention: _____

Patient Information:

Print name _____ Signature _____
Address _____ City _____ State _____ Zip _____
Date _____ Telephone No. (_____) _____ CIN _____ - _____ - _____

This information is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable laws.

Please return this form with requested information - Thank you
A copy of this authorization will be provided to the patient upon request

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California State University, Los Angeles
STUDENT HEALTH CENTER
Tele: (323) 343-3301
FAX: (323) 343-6557

Last Name _____
First _____
CIN _____