# RELEASE OF HEALTH INFORMATION

**I hereby authorize the Student Health Center at Cal State LA to release the following information.**

☐ Medical: _____

☐ Mental Health: _____

☐ Other: _____

Purpose of release: _____

This authorization is effective until _____. (date when it expires)

TO:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____

**I understand that by signing this authorization:**

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily. Treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand my personal health information disclosed under this authorization might be re-disclosed by the recipient, and my disclosed personal health information may no longer be subject to federal or state privacy laws protecting health records.

**Patient Information:**

Print Name_____ CIN_____

Signature_____ Date_____

OR Signed by Personal Representative:

_____ Date_____

On Behalf of:

_____

Name of Patient

CAL STATE LA | Student Health Center

**RELEASE OF HEALTH INFORMATION**

08142019

Last Name_____

First_____

CIN _____

**IDENTIFYING INFORMATION**

☐ Copy of Identification Attached

Type:_____ (California Driver's License, CA DMV Identification Card, Birth Certificate, Benefits Identification Card, Managed Care Card, State or Federal Employee ID Card)

Number: _____

**IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED**.

Notarized By: _____

On _____ (Date)

Notary Public Number: _____

**NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC**

**PERSONAL REPRESENTATIVE'S INFORMATION**

**PLEASE CHECK BELOW YOUR LEGAL AUTHORITY TO MAKE MEDICAL DECISIONS FOR THE PATIENT.**

☐ PARENT ☐ CONSERVATOR

☐ GUARDIAN ☐ EXECUTOR OF WILL

☐ MEDICAL POWER OF ATTORNEY ☐ OTHER _____

**NOTE:** ATTACHING LEGAL DOCUMENTATION IS REQUIRED TO VERIFY THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.