Campus Health & Wellbeing
Health Services
California Polytechnic State University
1 Grand Ave.
San Luis Obispo, CA 93407-0210
Office (805) 756-1211 Fax (805) 756-5298
Email: health@calpoly.edu

Authorization for Use and/or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____
Cal Poly Empl ID #: _____ Telephone: _____
Address: _____

Type of Access Requested: ☐ Copies ***or*** ☐ Verbal Exchange of Information

I authorize *Cal Poly Health Services* to:
☐ Release information to ***or*** ☐ Request information from

Name:_____ Telephone: _____

Street Address:_____ FAX: _____

City, State, Zip Code: _____

- ***Records to be:***

☐ Picked up ☐ Mailed ☐ FAXed (20 pages or less)

- ***Reason for release of information (initial one):***

_____ Personal File _____ Transfer of care _____ Other: _____

- ***Please release the following records (initial next to all that apply):***

_____ TB test results
_____ Immunization History
_____ Any and all information from (date): _____ to (date): _____
_____ Encounter notes (dates – excluding psychiatry) _____
_____ Psychiatric encounter notes _____
_____ HIV test results _____
_____ Lab/pathology results (Specify – excluding HIV results) _____
_____ Radiology/Imaging reports (Specify type and/or date) _____
_____ X-Ray Films (Charge for copies) _____
_____ Other information (Specify) _____

Continued on back

Consent

This information is intended for use by the above named recipient only. I am aware that the records released may contain information relating to medical conditions and treatments, psychiatric or psychological testing, physical abuse, drug and alcohol abuse, and education records covered by FERPA. This authorization will expire exactly one year from the date below or on _____. I have the right to receive a copy of this authorization. I may revoke this authorization at any time in writing. I understand that information used or disclosed under this authorization may be subject to redisclosure by the recipient without being further protected. I understand that I may be charged for copies provided. Incomplete information may cause a delay.

Copy of a valid drivers' license (including picture and signature) must be included with all mailed/FAXed/emailed requests.

☐ I authorize disclosure of my protected health information generated after the date of my signature, until the designated expiration as noted above, or revocation, whichever occurs first.

☐ I do not authorize disclosure of my protected health information generated after the date of my signature.

Patient Signature: _____ Date: _____

Please allow 15 days for processing. Health Services Policy on the Release of Protected Health Information is posted in Health Services. A copy will be made available upon request.

FOR HEALTH CENTER STAFF USE ONLY:

Received by: _____ Date: _____

☐ Identification checked/attached

DISPOSITION (*to be completed by Health Information*):

Records released by: _____ Date: _____

☐ FAXed:_____

_____

☐ Sent via U.S. Mail:_____

_____

☐ Left at Student Pick-up:_____

_____

☐ Given to Patient:_____