Revised 1/17/14

Health Services/California Polytechnic State University
San Luis Obispo, CA 93407-0210
Office (805) 756-1211 Fax (805) 756-5298

Please print. Must be completed in ink

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: ☐ 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):***

_____ Insurance
_____ Personal File
_____ Specialist consult
_____ School/Employment
_____ Transfer of care
_____ Moving out of area
_____ Legal
_____ Other ___________________________

➢ ***Please release the following records (<u>initial</u> next to all that apply):***
(Initials)
_______ TB test results
_______ Immunization History
_______ Any and all information from (date): ___________to (date): ______________
_______ Clinic notes (dates) ____
_______ HIV test results
_______ Lab/pathology results (Specify) ___________________________________
_______ Psychiatric visit notes ____
_______ 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 psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. 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 under the HIPAA rules. 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 and/or FAXed 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 Center. Copy available upon request.

FOR HEALTH CENTER STAFF USE ONLY:

Received by: ___________________________ Date: ____________________

☐ Identification checked/attached

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

Records sent by: ____________________________ Date: __________________

☐ FAXed:____

☐ Sent via U.S. Mail:____

☐ Left at Student Pick-up:_____________________________________

☐ Given to Patient:____