Revised 11/20/18

CAL POLY

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
***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: ***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):***

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

- ***Please release the following records (Need to <u>initial</u> next to all that apply):***

***(Initials)***

_____ 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*

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## *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. 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

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**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: _____

_____