Revised 8/7/17

Campus Health & Wellbeing
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Please print. Must be completed in ink

Authorization for Disclosure of Protected Health Information to Parents/Guardians

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:

Parent/Guardian Name(s):_____ Telephone: _____

Street Address:_____ FAX: _____

City, State, Zip Code: _____

- ***Reason for release of information:*** Consultation with parent(s)
- ***Please release the following records (check all that apply):***

☒ Any and all information from (date): _____ (MM/DD/YYYY) to (date): _____ (MM/DD/YYYY)*

☐ Other information (Specify) _____

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 on the end date listed above.* 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.

Patient Signature: _____ Date: _____

Health Services Policy on the Release of Protected Health Information is posted in Health Center. Copy is available upon request.

ID cked by: _____