Humboldt State University
Student Health Center
Arcata, CA 95521

Telephone: (707) 826-3146
FAX: (707) 826-5042

PATIENT AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Student ID#_____

Address: _____

Date of Birth: _____ Telephone No: _____ Email (optional) _____

I authorize:
(Person or facility that has health information)

Name: _____

Address: _____

_____

Phone: _____ FAX: _____

To release health information to:
(Person or facility to receive health information)

Name: _____

Address: _____

_____

Phone: _____ FAX: _____

Type of Disclosure: Initial to specify the type of information to be disclosed. ***Initials***

- ☐ All records _____
- ☐ Records limited to the following treatment _____ _____
- ☐ Records limited to the following time period _____ _____
- ☐ Gynecological records (describe) _____ _____
- ☐ Records pertaining to mental health, such as depression, eating disorders _____
- ☐ Drug/Alcohol information _____
- ☐ HIV results _____
- ☐ Other: _____ _____

For the following purposes only:

At the request of patient for continuity of care

Other: _____

Conditions of Authorization (HIPAA compliant)

Duration: This authorization is effective immediately and shall remain in effect until _____ or for one year from the date of signature.

Revocation: I may revoke this authorization at any time between now and the disclosure of information by the Student Health Center. My written revocation will be effective upon receipt but will not affect any actions taken by the Health Center before receiving my revocation.

Re-disclosure: This information is for use by the above-named recipient only. It cannot be given to any other individual or agency without my consent.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Office use Only: Mailed __ Hand Carried __ Faxed __ Approved By: _____

Records sent for __ Date: _____

6/09 slo