CALIFORNIA STATE UNIVERSITY, LONG BEACH

**STUDENT HEALTH SERVICES**

1250 Bellflower Blvd. Long Beach, CA 90840-0201 (562) 985-4771 **FAX: (562) 985-1644**

**AUTHORIZATION FOR THE RELEASE OR REQUEST OF MEDICAL INFORMATION**

Patient Name:_______________________________ Campus ID#:_______________

First Middle Last

Patient Address:_________________________________________________________

City:__________________________________ State:_______ Zip:________

Telephone: (____)______-________ Date of Birth: ____/____/_______

**Specific Information Release**:

Complete Medical Records_______ Lab/Pathology ___________ HIV________

Immunization Records __________ X-ray___________________

Other __________________________ Psychiatric visit notes______________________

**Check one of the following if releasing records**:

Please call me when records are ready to be picked up Mail certified

Please fax to _______________________ (Note: limited medical records faxed) e _________________________

**I understand the following**:

1. The recipient of the protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
2. I understand any disclosure of this information carries a potential for ar est. unauthoris Aalthorization will be provided by Student He

4. Revocation of this Authorization may be done at any time by mailing or personally delivering a signed, written notice of revocation to the Medical Records Dept. of Student Health Services. Such revocation will be effective upon rececati(a)-1.7 (7