AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Sender: Name of individual/organization: _____ Phone:_____
Mailing Address: _____ Fax:_____

I authorize the above-named facility to release the following health information as described below (check the appropriate spaces and include other information where indicated):

_____ The entire health record (all information)	_____ Medical records
_____ Radiology reports (x-ray, ultrasound, CT/MRI, etc.)	_____ Psychiatric records
_____ Laboratory reports (blood tests results, urine tests results etc.)	_____ TB Skin test records
_____ Immunization records	_____ Hospital records (ER)
_____ Physical examinations	_____ Counseling summary
_____ Health records regarding sexually transmitted infections*	_____ Counseling attendance
_____ Other: (Describe as specifically as possible). _____	

*Please note: In accordance with CDC guidelines, all HIV/AIDS records are reported to the recipient in person before the records may be released via phone, mail, or fax. A separate signed consent is required for each release of records related to HIV/AIDS health records.

Recipient: La Sierra University Student Wellness Services, 4500 Riverwalk Parkway, Riverside, CA 92515-8247 Phone: (951) 785-2200 Fax: (951) 785-2263 Email: wellness@ lasierra.edu*

Purpose of use/disclosure: This information will be used for the following purpose(s):

☐ Patient's request ☐ My personal records ☐ Continued care ☐ Other (please describe): _____

Authorization Statements/Signatures:

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. Unless I specify differently, this authorization will expire (insert date):_____
4. I understand that La Sierra University Student Health Services will not condition the provision of treatment or payment on the provision of this authorization.

_____ _____ _____
Signature of Patient or Personal Representative | Print Name | Date

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

*Electronic transmission of information is **NOT** guaranteed to be secure. It is not advised to request that SENSITIVE records be transmitted in this way.