Santa Clara University
Cowell Center - Student Health Services

Release to have CCSHS send medical documents

Authorization for use and/or disclosure of patient health information

I understand that Cowell Student Health Services will not condition treatment, payment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize: Cowell Center - Student Health Services - Santa Clara University
500 El Camino Real Santa Clara, CA 95053
T: 408-554-4501 F: 408-554-2376

To disclose to: Name: _____

Address: _____

Tele #: _____Fax: _____

Records and information pertaining to: Patient Name: _____Date of Birth: _____

Student ID (only the last four numbers): ____ ____ ____ ____

Address: _____

Tele #: _____

Duration: This authorization shall become effective immediately and shall be in effect for one year from the date of signature unless a different date is specified here _____.

Revocation: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

We are requesting the following medical information:
(Please specify records by checking the box to indicate which type of information is to be disclosed)

_____Clinic visit notes _____Laboratory reports _____Consultation Reports
_____Immunization Records _____Results of TB testing

___Related to: _____

___Other: _____

Requests for the following types of information require signature for each:

Psychiatric/Mental Health	HIV test results
Signature/Date	Signature/Date

The recipient may use the health information authorized on this form for the following purposes:

_____

_____ _____ _____/_____/_____

Print Name **Patient Signature** **Date**