Santa Clara University
Cowell Center - Student Health Services

Release to have medical documents sent to CCSHS

Authorization for use and/or disclosure of patient health information

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

I hereby authorize: Name of Disclosing Party: _____

Address:_____

Tele #:_____Fax #_____

To disclose to: Cowell Center - Student Health Center - Santa Clara University
500 El Camino Real Santa Clara, CA 95053
T: 408-554-4501 F: 408-554-2376

Records and Information pertaining to: Patient Name: _____Date of Birth_____

SCU 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)

____ Emergency room records
____ Transcribed hospital records
____ Consultation reports
____ Xray/Imaging reports
____ Clinician office chart notes
____ Operative reports
____ Laboratory reports
____ Immunization Records

___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:

_____

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_____	_____	_____/_____/_____
Print Name	**Patient Signature**	**Date**