Santa Clara University

Cowell Center - Student Health Services (SHS)
PERMISSION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the Cowell Center at Santa Clara University located at 500 El Camino Real Bldg. 701, Santa Clara, CA 95053; **Phone**: (408) 554-4501 **Fax**: (408) 554-2376

☐ **Disclose information to** ☐ **Receive information from** ☐ **Exchange information with**

Name: _____

Address: _____

Phone Number: _____ Fax: _____

Records and information pertaining to:

_____
Name Date of Birth Student ID

_____
Address City State/Zip Daytime Phone

INFORMATION TO BE DISCLOSED:

☐ Emergency room records ☐ X-ray/Imaging reports ☐ Lab Reports
☐ Transcribed hospital records ☐ Clinician office chart notes ☐ Consultation reports
☐ Immunization Record ☐ Operative reports
☐ Related to: _____
☐ Other (specify):_____

The following information requires a signature and date:

HIV Test Results ☐ Yes ☐ No	Psychiatric / Mental Health ☐ Yes ☐ No
Signature/Date	Signature /Date

EXPIRATION: This authorization will become effective immediately and shall be in effect until
☐ End of academic year ☐ Date specified: _____

REVOCATION: I understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

YOUR RIGHTS: This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for services is not contingent upon my signing this release form.

RE-DISCLOSURE: I understand that any re-disclosure of the above information is prohibited beyond this release and that any such re-disclosures require a new Release of Information Form signed by me.

_____ _____ _____
Print Name Patient Signature Date