klotz
student health center

For a copy of your medical records, please follow these steps:

1. Complete the two page “Release of Records” form

2. Include copy of your ID

3. Fax it to 818-677-2304 or submit it in person

It may take up to 10 business days to process.

California State University
Northridge
18111 Nordhoff St. • Northridge • California • 91330-8270 • phone (818) 677-3666 • fax (818) 677-2304

klotz student health center

NAME (PRINT) _____

ID NUMBER _____ Date of Birth _____

Phone Number(s)/E-mail Address _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the use or disclosure of my health information as described below by the Klotz Student Health Center, California State University Northridge, 18111 Nordhoff Street, Northridge, CA 91330-8270.

Picture ID is required to release any information. Please complete the 6 steps.

1

FORMAT OF RECORD ☐ Hard Copy ☐ CD ($5 fee) ☐ Fax (Fax Number: _____)

2

2. RECIPIENT: The information authorized above may be disclosed to and used by the following individual or organization:

Recipient Name or Entity _____

Recipient Street Address _____

Recipient City, State, and Zip Code/Postal Code _____

3

3. AUTHORIZATION: Please complete this section indicating what records to be released and/or disclosed. First ten pages are free, each additional page is $0.10. Lab and x-ray results cannot be released until the provider has reviewed the results with the patient.

☐ Consultation Reports/Clinic Notes from _____ (Date) to _____ (Date)

☐ Immunization Record

☐ Most Recent Glasses/Contact Lens Prescription

☐ Laboratory results from _____ (Date) to _____ (Date)

☐ X-ray and Imaging Reports from _____ (Date) to _____ (Date)

☐ Most recent history and physical

☐ Other: _____

☐ Entire record ($0.10 a page)

4

OPTIONAL: ☐ HIV Test Results _____ (Signature of Patient or Patient's Representative) _____ (Date)

PSYCHOTHERAPY RECORDS I understand that the information in my health record may also include information about behavioral or mental health services, and that if I wish to have psychotherapy records disclosed, I must sign a separate written authorization that complies with California Civil Code § 56.10 and, if applicable, § 56.104. ***A general authorization for the release of medical or other information is NOT in all cases sufficient for this purpose.***

ALCOHOL & DRUG TREATMENT RECORDS

I understand that the information in my health record may also include information about treatment for alcohol and drug abuse, and that if I wish to have such records disclosed, I must sign a separate written authorization that complies with federal law (including C.F.R. 42 U.S.C. § 290dd-2 and Part 2). ***A general authorization for the release of medical or other information is NOT sufficient for this purpose.***

5

OPTIONAL: REVOCATION, DURATION & REDISCLOSURE

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date:_____ (If I fail to specify an expiration date, event or condition, this authorization will expire automatically in 90 days)

6

SIGNATURE: I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment at the SHC. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR § 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Michelle Runkle, RHIA, Assistant Director, Health Information Management at 818-677-5590. I understand that I am entitled to receive a copy of this authorization.

_____

Signature of Patient or Legal Representative

_____

If Signed by Legal Representative, Relationship to Patient

_____

Date

_____

Signature of Witness

California State University Northridge