CSU-DOMINGUEZ HILLS
STUDENT HEALTH SERVICES
MEDICAL RECORDS REQUEST AND RELEASE FORM
(310) 243-3629
(310) 217-6990 (Fax)

Attention: The patient must complete this form in its entirety in order for any healthcare facility to release medical information. The patient must be specific as to the nature of the information he/she would like released and the purpose for which it is requested. Please initial options.

DATE:_____

_____
(Please Print) LAST NAME FIRST NAME MI DATE OF BIRTH ID#

_____
ADDRESS ZIP CURRENT PHONE #

I, THE UNDERSIGNED, HEREBY AUTHORIZE THE: (Please initial options)

_____ CSUDH – STUDENT HEALTH CENTER

_____ OTHER HEALTH CARE FACILITY (SPECIFY: NAME, ADDRESS & ZIP)
_____

TO PROVIDE THE FOLLOWING RECORDS PERTAINING TO MY HEALTH: (Please initial options)
_____ ALL RECORDS
_____ HISTORY AND PHYSICAL FORM ONLY - SPECIFY DATE(S)_____
_____ SUMMARY OF RECENT CARE INCLUDING PATIENT VISITS, LABORATORY RESULTS, X-RAY, DIAGNOSIS AND TREATMENTS. SPECIFY DATE(S) _____
_____ OTHER (SPECIFY) _____
_____

FOR THE FOLLOWING REASON(S): (Please initial options)
_____ BEING FOLLOWED BY CSUDH-STUDENT HEALTH CENTER
_____ BEING FOLLOWED BY OUTSIDE PHYSICIAN
_____ INSURANCE
_____ EMPLOYMENT
_____ QUALIFICATION FOR BENEFITS
_____ COURT SUBPOENA
_____ OTHER (SPECIFY)_____

PLEASE RELEASE MEDICAL RECORDS TO: (Please initial options)
_____ PATIENT
_____ CSUDH - STUDENT HEALTH CENTER A-129, 1000 E. VICTORIA STREET, CARSON, CA 90747
_____ OTHER (SPECIFY: NAME, ADDRESS & ZIP CODE)_____
_____

❑ Please call me when records are ready to be picked up ❑ I will pick up records
❑ Mail records as requested ❑ Fax records as requested (____)_____
(Fax Number)

I understand I may inspect or obtain a copy of the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug (substance) abuse, or any such related information.

_____ _____
Patient Signature **Parent's signature if Patient is under 18 years old**

_____
Witness

This form is designed to comply with the legislative revision of Division I, Part 2.6 (commencing with section 56 of the California Civil Code) and Federal Law. The intentional re-disclosure of this information may subject you to a civil action under Section 1798.53 of the Civil Code for invasion of privacy by the individual(s) to whom the information pertains. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

For office use only:

DATE RELEASED_____BY_____TITLE_____

DATE ENTERED IN LOG_____BY_____TITLE_____

COPY OF RECORDS: ❑ **Given to Patient** ❑ **Mailed to Patient** _____ **Date** ❑ **Mailed as requested** _____ **Date** ❑ **Faxed as requested** _____ **Date**

❑ NOTATION WRITTEN IN MEDICAL RECORD

Original - Medical Record (White) Copy - Patient (Pink)

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