THE CLAREMONT COLLEGES SERVICES

Student Health Services

RELEASE OF MEDICAL RECORDS AND MEDICAL INFORMATION
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please fill out this form carefully and completely. REQUIRED by the Health Insurance Portability and Accountability Act, (45 C.F.R. Parts 160 and 164).
Use Ink & Print Clearly

I, _____DOB_____authorize Student Health Services to use or disclose my protected health information including any photographs that have been taken to assist in my care as indicated below to:

Name: _____
(Complete Name: Parent, Spouse, Physician, Employer or Other)

Daytime Phone# _____ **Fax#** _____

Address _____

City _____ **State** _____ **Zip Code** _____

2. Information to be released: Identify dates and specific request

From & To Dates: _____ ☐ Lab report: _____

☐ History and physical exam: _____ ☐ X-ray report: _____

☐ At the request of the individual _____

Other: _____

_____

3. Authorization: Please read carefully

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am **specifically authorizing the release** of information relating to:

☐ Substance Abuse (including alcohol/drug abuse)

☐ Mental Health

☐ Psychotherapy Notes

☐ HIV related information (including AIDS related testing)

☐ Other (please specify): _____

The confidentiality of this record is required under California Health & Safety Code 120975 to 21020, as well as, title 42 of the United States code. The material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

X _____ _____
Signature of Patient or Legal Guardian Da

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1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I **may revoke this authorization at any time by notifying the SHS Medical Records Manager** at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I may obtain a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ _____
Signature of Patient Date of Birth Date

_____ _____
Parent/Legal Guardian/Authorized Person Relationship to Patient

_____ _____
Record Received By Date

For Office Use Only

Date Requested Filled _____ By _____

Identification Presented _____ Fee Collected _____