THE CLAREMONT COLLEGES
SERVICES

Student Health Services
757 N College Way, Claremont, CA 91711
Phone (909) 621-8222
Fax (909)621-8472

Authorization for Use or Disclosure of Protected Health Information

I, ______________________________________ DOB: ___/___/___, hereby authorize the use and disclosure of my protected health information by Student Health Services as follows:

☐ Release Information to *and/or* ☐ Request Information from

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

Phone: ____ Fax: ______________________________________

Address: ____

City: ____ State: ___________ Zip Code: ______________

The requested information is to be used for the following purpose: ________________________________

Information to be disclosed:

Records dated from _____ /_____/_____ to _____/_____/_____

☐ All Medical Records ☐ Clinic Notes ☐ Medical History/Physical Exam ☐ Immunization Records
☐ Lab Report ☐ X-Ray Report ☐ X-Ray Images ☐ EKG ☐ Other: ____________________________

Specific Authorization: The following information will not be released unless you specifically authorize it by initialing the relevant line(s) below.

____ Alcohol/Drug Use, Treatment and/or Evaluation ____ Mental Health/Psychiatric Records ____ HIV/AIDS

I understand that by signing below:

- I authorize the use or disclosure of my protect health information as described above
- I have the right to revoke that authorization at any time. The revocation must be made in writing to Student Health Services at the address or fax number indicated above and will be effective once it is received by SHS. I understand that such revocation will not affect information that has already been used or disclosed.
- I understand this authorization is effective immediately and, if I do not revoke it sooner in writing, will remain in effect for one year for mental health records from the date signed.
- I further understand that if the person and/or organization authorized by this form is not a health care provider, the health information they receive may no longer be protected by federal privacy law. However, California law prohibits a person and/or organization to whom health information is disclosed pursuant to this authorization from re-disclosing my personal health information except with my written authorization or as specifically required or permitted by law
- I have the right to receive a copy of this authorization. A photocopy of this form is valid.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

____
Signature of Patient or Patient's Representative   Indicate Relationship (if signed by other than patient)   Date

____
Signature of Witness   Name of Witness   Date