The Campus Health Center at California State University, Monterey Bay

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:_____

Patient ID (or SSN) Number _____ Date of Birth_____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

   _____

   Address _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

   ☐ problem list ☐ immunization record ☐ most recent history and physical

   ☐ most recent discharge summary

   ☐ laboratory results from (date) _____ to (date)_____

   ☐ x-ray and imaging reports from (date) _____ to (date)_____

   ☐ consultation reports from (doctors' names) _____

   ☐ entire record (except ☐ other _____

   _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), *and that I must sign a separate authorization form for each separate disclosure of this information.*

5. 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.*

6. ALCOHOL AND 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 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2). *A general authorization for the release of medical or other information is NOT sufficient for this purpose.*

Campus Health Center at CSUMB
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION, Continued

7. The information described above may be disclosed to and used by the following individual or organization: _____
   Address: _____
   _____
   for the purpose of: _____

8. 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 not be valid.***

9. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. 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 Flo Miller at the Campus Health Center at CSUMB (831/582-3623). I understand that I am entitled to receive a copy of this authorization.

_____ / _____
Signature of Patient or Legal Representative Date

If Signed by Legal Representative, give relationship to patient _____
When applicable, PRINT Name & Address of Legal Representative
_____
_____
_____
_____

Signature of Witness: _____