Authorization for Release of Protected Health Information

Saddleback College Student Health and Wellness Center
28000 Marguerite Parkway, CC 177
Mission Viejo, CA 92692

Phone: 949.582.4606 / Fax: 949.582.4227

STUDENT/STAFF ID #

DATE OF BIRTH

PATIENT PHONE NUMBER

LAST NAME

FIRST NAME

I request and authorize *Saddleback College Student Health and Wellness Center* to release the information specified below to the agency, organization or individuals named on this request. (Please allow 24-48 hours for *Medical Records* and up to 5 business days for *Mental Health Summaries*) To be picked up within 30 days from request.

- ☐ TB Test
- ☐ Immunizations
- ☐ Complete Health Record
- ☐ Laboratory Tests
- ☐ Psychological/Mental Health Summary
- ☐ Other_____

Reason for requesting information.

Covering the period of health care dates: From: To:

Release records to:

- ☐ Self
- ☐ Employer
- ☐ Doctor
- ☐ Named Individual
- ☐ Agency

Name(s) of Individual(s)/Agency/Employer picking up or receiving information :

If Mailing, Name of Recipient

How do you prefer to receive information?

- ☐ Will Pick Up
- ☐ Postal Mail
- ☐ Fax

Street Address

Fax # of Recipient (include area code)

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

Patient Rights:
I certify that this request has been made voluntarily. I understand that information about my case is confidential and protected by state and federal law. I understand this authorization will EXPIRE 180 DAYS from the date of my signature. I may revoke this authorization by writing a letter to the releasing office/health center. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if it's purpose was to obtain insurance.

Once the office/health center discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I understand what this agreement means, and that I am entitled to a copy of this form. A copy or fax of this release is as valid as the original.

Copies of PHI records are eligible for release within 30 days after receipt of the provided written request form. For details regarding your rights as a patient, please review the "Your Rights" section of the *Notice of Privacy Practices.*

Patient Signature

Today's Date