SJSU | STUDENT WELLNESS CENTER

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Authorization for Release of Information/Records

Completing this form authorizes the Student Wellness Center (SWC) to release information and health care records to the person/agency indicated below.

Client/Patient Information

Name: _____ Student ID#:_____ Date of Birth:_____

Email:_____ Phone:_____

Briefly explain the reason for the request and specific information needed:

_____

Person/Agency for Disclosure

The information/records may be disclosed to:

Name Person/Agency:_____ Phone of Person/Agency: _____

Email of Person/Agency: _____ Fax of Person/Agency: _____

Address of Person/Agency: _____

Information Parameters

I consent to the release/disclosure of (Check all appropriate boxes):

- ☐ Any information/records deemed appropriate (permits conversation/dialogue; not just record release)
- ☐ Verification of Treatment
- ☐ Complete Medical Records (Excluding Psychiatric)
- ☐ Counseling Records (Excluding Psychiatric)
- ☐ Psychiatric Records
- ☐ Alcohol/Substance Abuse Records
- ☐ Gynecological including Pap Smears
- ☐ Pharmacy Records
- ☐ HIV Records
- ☐ X-ray/Laboratory Tests (specify):_____ _____
- ☐ Immunization (specify):_____ _____
- ☐ Physical Exam (date):_____
- ☐ Records pertinent only to my appointments on or about (date):_____
- ☐ Other:_____

Send Records via:

☐ Secure Email ☐ Fax ☐ In Person Pick Up

Client Consent/Signature

I consent to the release as indicated above. I understand and acknowledge that: 1) I have the right not to consent to the release of information contained in my health records 2) authorization may be revoked in writing at any time 3) A copy of this release will be placed into my patient records & I have a right to receive a copy of this authorization form upon my request.

Client Signature _____ Date _____

OFFICE USE ONLY / How was the request handled?

Request was made: [ ] In Person [ ]Email [ ] Fax

Received by:_____ Date:_____

Completed by:_____ Date:_____

Additional Information/Notes:

_____

_____