SJSU | STUDENT WELLNESS CENTER

Accredited by Association for Ambulatory Health Care

Division of Student Affairs
One Washington Square
San José, CA 95192-0031
studentwellnesscenter@sjsu.edu
Ph 408.924.5678 Fax 408.924.7786

Authorization to Request or Release Medical Information

Student/Patient _____ SID _____

I authorize the Student Wellness Center's Health Services, to release information to:

Name of Recipient _____

- ☐ Pick Up in Person
- ☐ Mail to Postal Address_____

I am requesting copies of the following information from my medical record:

- ☐ Complete Medical Records
- ☐ Mental Health Records
- ☐ HIV Records
- ☐ Pap Smears
- ☐ Gynecological including Pap Smears
- ☐ Alcohol/Substance Abuse Records
- ☐ X-ray/Laboratory Tests (specify):
- ☐ Immunization (specify):
- ☐ Physical Exam (date):
- ☐ Records pertinent only to my illness on or about (date):
- ☐ Other:

This authorization is for the purpose of _____

This authorization shall expire 60 days from the date below or on _____. It may be revoked in writing at any time. I understand that I have a right to receive a copy of this authorization form upon my request.

Copy requested: ☐ Yes ☐ No

Patient's signature: _____ Date: _____

Address: _____

Phone: _____ Birthdate: _____

Witness Name:_____

Submit completed and signed form to Student Wellness Center in person or fax to 408.924.7786
Please allow up to 15 days to process your request. You will be contacted when copies are available for pickup.
Payment is required upon receipt. There is no charge for copies sent to another provider/facility.

SWC Employees Only:

Records released by: _____ Date _____