Student Health Service
San Francisco State University
1600 Holloway Avenue
San Francisco, California 94132-4200
(415) 338-1251

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on my providing or refusing to provide this authorization.

Patient: _____
LAST NAME FIRST NAME MIDDLE MAIDEN

___/___/___ _____ ☐ CURRENTLY ATTENDING
DATE OF BIRTH ID NUMBER ☐ LAST SEMESTER ATTENDED_____

I Authorize: _____
NAME OF DISCLOSING FACILITY OR PERSON

_____
ADDRESS CITY STATE ZIP

To Disclose: _____
NAME OF RECEIVING FACILITY OR PERSON

_____
ADDRESS CITY STATE ZIP

The following Health Information:

☐ General Medical (Excludes Women's Services) ☐ Gynecological (Including Pap Smears)
☐ Physical Exams (Specify) _____
☐ X-Rays (Specify) _____
☐ Laboratory Test (Specify) _____
☐ Immunizations (Specify Year) _____
☐ Mental Health Services (Specify Year) _____
☐ HIV Test Results ☐ Alcohol Treatment ☐ Drug Abuse Treatment
☐ Other (Specify) _____

Please read before signing:

SFSU-Student Health Service maintains your health information as strictly **CONFIDENTIAL**.
Your request is voluntary. You have the right to receive a copy of this request. This authorization may be revoked in writing by the patient at any time before the date of expiration. The revocation must be in writing, signed by you or Your patient representation, and delivered to SFSU-Student Health Services, Attention Custodian of records, 1600 Holloway Avenue, San Francisco, California 94132.

I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically requested or permitted by law.

Purpose of this release is for (check one or more): ☐ At the request of the patient
☐ Patient representative ☐ Other (state reason) _____

This authorization shall expire one year from the date below or on _____

Patients Signature _____ Date _____

Address _____ Telephone (___)_____

Witness Name _____ Date _____

FOR SFSU USE ONLY **RECORDS REQUESTED or RELEASED BY:** _____ **DATE** _____

SHS 103—5/2011 **WHITE-TO BE MAILED** **CANARY-TO CHART** **PINK-TO PATIENT**