San Francisco State University
Gator Student Health Services

1600 Holloway Avenue,
San Francisco, CA 94132-4200
Phone: (415) 338-1251 Fax: (415) 405-2658

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.

Name: _____ Date of Birth: _____ ID#_____

By checking the following, I acknowledge and agree to the statements below

SFSU-Student Health Services maintain my health information as strictly CONFIDENTIAL

☐ My request is voluntary

☐ I have the right to receive a copy of this request

☐ I may revoke this authorization at any time before the date of expiration. This revocation must be in writing, signed by myself or my representative, and delivered to SFSU-Student Health Services.

This release of information is made:

☐ At my request

☐ At my representative's request

☐ For other purposes

☐ Continuation of Care

**** Please specify the health information you authorize to be released. Please check all that apply.**
For dates of service:_____

☐ General Medical (Excludes Gynecological Services)

☐ Physical Exam(s) (Specify)

☐ Radiology Test(s) (Specify)

☐ Gynecological (Including Pap Tests)

☐ Immunization(s) (Specify)

☐ Laboratory Test(s) (Specify)

☐ Billing records

The following information will NOT be released unless you specifically authorize it by checking the relevant items below:
For dates of service: _____

☐ Mental Health Service(s) (Specify)

☐ Gender Affirming Care records

☐HIV Test Results

AUTHORIZATION

☐ understand that the requester may not further use or disclose this health information without my written authorization, unless such use or disclosure is specifically requested or permitted by law.

☐ authorize the release of above information FROM the person/provider/agency named below TO SFSU Student Health Services.

☐ authorize the release of the above information FROM SFSU Student Health Services TO the person/provider/agency named below.

Name of person/provider/title: _____

Name of agency/department/relationship: _____

Mailing/Campus address: _____

Phone number: _____ Fax number: _____

This authorization is effective as of the date of signature and will expire by: _____
Date

Student Signature: _____ Today's Date: _____