

**San Francisco State University
Student Health Services**

730 Font Blvd. 2nd Floor
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.**

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:

Dates of Treatment: _____

- Mental Health Service contact CAPS caps@sfsu.edu
- HIV Test Results
- Gender Affirming Care records

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: _____