

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO  
STUDENT HEALTH CENTER  
(909) 537-5241

PLEASE PRINT

**RELEASE OF MEDICAL RECORDS**

\_\_\_\_\_  
Last Name                      First Name                      M.I.                      Date of Birth

\_\_\_\_\_  
Complete Address

I, the undersigned, hereby authorize the :

**Student Health Center at Cal State University, San Bernardino**

to release or disclose the following records, mark all that apply:

- General medical information (from \_\_\_\_\_ to \_\_\_\_\_)  
 Xray Results dated \_\_\_\_\_  Laboratory Results dated \_\_\_\_\_  
 Last Pap and Progress notes  Immunizations  
 Other (Specify): \_\_\_\_\_

**Allow 7 - 10 days for Processing**

I understand that the information in my medical record may include information relating to sexually transmitted disease, AIDS, or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, & treatment for alcohol and drug abuse. **\*Please initial** \_\_\_\_\_

\*Please release records by mail or Fax to: **(Specify Name, Address, Zip Code and fax # if applicable)**

\_\_\_\_\_  
\_\_\_\_\_  
**Please note: We DO**

\_\_\_\_\_  
**FAX #:** \_\_\_\_\_

**DURATION:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_(enter date) or for one year from the date of signature if no date entered.

**REVOCATION:** This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the SHC. Written revocation will not affect any action specifically required or taken in advance of this authorization before the written revocation was received.

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

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Student ID #

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Witness Signature

**OFFICE USE ONLY:**

Date mailed / faxed (circle one) Please initial completed by: \_\_\_\_\_

Date given to student or left at front office for pick-up

11/08 release of medical records erb

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

=====

\_\_\_\_\_