

Authorization for the Release or Request of Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone #: _____ CWID: _____

I Authorize CSUF TitanMED to: (choose one)

___ Release my private health information to

___ Request my private health information from

Name: _____

Address: _____

Phone#: _____ Fax#: _____ (maximum 5 pages)

This authorization will expire on _____ or 90 days from the date signed.

This authorization is limited to the following information only:

- | | |
|---|---|
| <input type="checkbox"/> Complete Records | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Lab/Pathology _____ |
| <input type="checkbox"/> Chiropractic Records | <input type="checkbox"/> X-Ray Report <input type="checkbox"/> X-Ray Film |
| <input type="checkbox"/> HIV Result/PEP/PEP _____ (initial) | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Billing (dates of service) _____ | <input type="checkbox"/> Other _____ |

Records are being disclosed for the following purpose:

Continuing Care Personal Records Other: _____

Records will be:

Picked Up Faxed Certified Mail Titan Health Portal (not all records can be placed on the portal)

This Authorization for disclosure and release of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56 et. Seq., of the California Civil Code, the Health and Safety Code, Section 199.21 (g) and the Lanterman-Petris-Short Act, alcohol and drug abuse regulation, Welfare and Institutions Code Section 5328.7

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand this authorization is voluntary.
- I reserve the right to revoke this authorization in writing, at any time to CSUF's Student Wellness. The authorization will stop further release of my protected

health information on the date my valid revocation request is received by Student Wellness. [45 C.F.R. §164.508(c)(2)(ii)]

- I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]
- Under California law, the recipient of the protected health information under the authorization is prohibited from redisclosing the protected health information, except with a written authorization or as specially required or permitted by law [Civil Code § 56.13]
- I understand any disclosure of this information carries a potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. [45 C.F.R. § 164.524(a)(2)(v)]
- I have the right to receive a copy of this authorization. [45 C.F.R. § 164.508(c)(4) & Civ Code § 56.11(i)]
- Reasonable fees may be charged to cover the cost of copying and postage related to releasing this protected health information. [45 C.F.R. § 164.524(c)(4) et seq. & California Health and Safety Code §123110, et seq.]
- Please be advised that we may have to get prior approval from a provider if your results have not yet been discussed with you, before releasing your records.

Signature of Patient: _____ Date: _____

Charges for records will post to your student account within 48 hours. At that time, you may make a payment online via your Titan Online Student Center, in person at GH-180 Window 6 or contact Student Business Services at (657)278-4295 for other payment options.

Any records exceeding 5 pages will be put on a USB
Charges will be assessed after preparation of records
Records on USB: \$5 X-Ray Film on Disc: \$5

By completing this release, I and am aware of the possibility of a charge for a copy of my medical records.

For Medical Records Department Use Only

Total Pages: _____

Total Charge: _____

Disclosed by: ___ Paper ___ USB ___ Fax ___ Titan Health Portal (*not all records can be placed on the portal*)

Records prepared by: _____ Date: _____

Records picked up on: _____ Records delivered by: _____