



Student Health Center
5998 Alcalá Park, C-161
San Diego, CA 92110
Tel: 619-260-4595
Fax: 619-260-2375

Authorization for Release of Patient Information

Your Right to Medical Information Confidentiality: By law, if you are 18 years or older, you have the right to strict confidentiality regarding your visits to medical providers, including the University of San Diego Student Health Center. In order to release any information including the date or nature of your visit, to the Student Health Center or from the Student Health Center, you must sign consent with specific directions about what information you are consenting to be released.

Without written consent, the Wellness Area, which the Student Health Center is a part of, cannot release or discuss any information relating to your visit with anyone including your parents, guardians, spouse, faculty, staff, coach and other medical professionals.

The following regulations apply to the release of patient information at the USD Student Health Center: If the person(s) listed below to receive patient information, are not health care providers, health plans, or health care clearinghouses, which must follow the federal privacy standards, the health information released as a result of this authorization may no longer be protected by the federal privacy standards and health information may be disclosed without obtaining your consent.

If this request for patient information is for the purpose of continuing medical care, we will attempt to process the request within 72 hours. Allow up to 30 days for all other request, including legal, personal, and applications for life, health, and disability insurance.

If the medical records are to be released directly to the patient, or released for continuing treatment to a physician, hospital, clinic, or other medical facility there will be no charge. There may be a fee of \$35 for the first 25 pages and \$0.75 for each additional page for medical records released to other entities.

This Consent to Release Patient Information is valid for 1 year, unless revoked by patient prior to this date.

Authorization to release patient information may apply to verbal discussions, visual inspections, faxing, and/or photocopying of information in your medical record.

Information to be Released: Unless you tell us otherwise, USD Student Health will SEND / REQUEST the last two years medical history and the last one year of lab, X-Ray, and EKG reports. This release includes HIV status, alcohol and drug information.

Other information you want sent or obtained:

Purpose of this request:

- Continuing Medical Care
 - Legal
 - Personal
 - Insurance
 - Other (please specify)
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Release of Patient Information:

- I authorize USD Student Health Center to SEND my medical records TO:

Send to (Name of Physician or Medical facility):

Fax # or mailing address:

- I authorize USD Student Health Center to OBTAIN my medical records FROM:

Obtain from (Name of Physician/Medical Facility):

Fax # or mailing address:

- I authorize USD Student Health Center to discuss my condition/treatment with my parents

Name:

Relationship:

Phone #:

Name:

Relationship:

Phone #:

- I authorize USD Student Health Center to release information to USD Athletic Trainers

- Other

Please Specify:

Print Name of Student: _____ USD ID# _____ Birthdate: _____

Signature of Student: _____ DATE: _____