Last Name:_____ DOB:_____

University of San Diego®
STUDENT HEALTH CENTER

Student Health Center
5998 Alcala Park, Maher 140
San Diego, CA 92110
Phone: (619) 260-4595; Fax: (619) 260-2375

# Authorization to Release 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 a consent form 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 requests, 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 copying medical records released to other entities.

This Consent to Release Patient Information is valid for 1 year, unless revoked by the 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 of medical history, labs, X-rays, EKG reports, and outside medical records. This release includes HIV status, alcohol, and drug information.

- ☐ Immunization Records Only
- ☐ All Records (All radiology, EKG Reports, and records from medical providers outside of USD)
- ☐ All records dated: from: _____ to _____
- ☐ Other requests: _____

**Purpose of this request**:

- ☐ Continuing Medical Care
- ☐ Legal
- ☐ Personal
- ☐ Referral (please, specify) _____
- ☐ Other: _____

Last Name:_____ DOB:_____

**Release of Patient Information** (To Send and/or Obtain):

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

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

☐ I authorize USD Student Health Center to ***SEND AND OBTAIN*** my medical records ***TO AND FROM:***

*Contact information for the person sending and/or obtaining medical record*:

☐ Self ☐ Parent(s) ☐ Physician ☐ Other:_____

Name (Self, Parent, Physician, or Medical Facility): _____

Phone Number: _____

☐ MAIL: _____

☐ FAX: _____

☐ PICK UP: At the Student Health Center

**NOTE: We are not able to send medical records via email.**
**Your options to receive records include mail, fax, or pick up in person at the Student Health Center.**

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**Release of Patient Information** (To Discuss):

☐ I authorize USD Student Health Center to ***DISCUSS*** my condition/treatment with:

*Contact information for the person I am authorizing the Student Health Center to discuss my condition/treatment with:*

☐ Parent(s) ☐ USD Athletic Trainer(s) ☐ Other:_____

Name: _____

Relationship: _____

Phone Number: _____

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**Student Name (PRINT):** _____ **USD ID#:**_____ **DOB:** _____

**Student Signature**: _____ **Date:** _____