Student Health Center - One Washington Square - San Jose, California 95192-0037 408/924-6150 Fax 408/924-7786
Accredited by Association for Ambulatory Health Care

AUTHORIZATION TO REQUEST OR RELEASE MEDICAL INFORMATION

PATIENT: _____
LAST NAME FIRST NAME

I AUTHORIZE: _____
HEALTHCARE PROVIDER

_____
ADDRESS

_____
CITY STATE ZIP CODE

TO RELEASE TO: _____
NAME OF RECIPIENT

_____
ADDRESS

_____
CITY STATE ZIP CODE

I AM REQUESTING COPIES OF THE FOLLOWING INFORMATION FROM MY MEDICAL RECORD:

☐ Complete Medical Records ☐ ***HIV Records*** ☐ ***Mental Health Records***

☐ X-ray/Laboratory Tests (specify): _____

☐ Immunization (specify): _____ ☐ Physical Exam (date): _____

☐ Pap Smears ☐ Gynecological including Pap Smears ☐ ***Alcohol/Substance Abuse Records***

☐ Records pertinent only to my illness on or about (date): _____

☐ Other: _____

This authorization is for the purpose of _____

This authorization shall expire 60 days from the date below or on _____. It may be revoked in writing at anytime.

I understand that I have a right to receive a copy of this authorization form upon my request.
Copy requested & received: _____ *YES* _____ *NO*

Patient's signature _____ Date: _____

Address: _____

Phone: _____ Birthdate: _____

Student ID # : _____ Witness: _____

Please allow up to 15 days to process your request. You will be contacted when copies are available for pickup. Payment is required upon receipt. There is no charge for copies sent to another provider/facility.

FOR SJSU ONLY:

RECORDS REQUESTED OR RELEASED BY: _____ _____
HEALTH RECORD TECHNICIAN DATE