AUTHORIZATION TO RELEASE <u>CONFIDENTIAL</u> INFORMATION

California State University, East Bay
Student Health & Counseling Services
25800 Carlos Bee Blvd
Hayward, CA 94542
Phone: (510) 885-3735
Fax: (510) 885-3230
Email: **shcs@csueastbay.edu**

Patient Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ______________________________

Birthdate: ____________________ Net ID: ________________

I authorize release **FROM**: *(Name of **disclosing** party)*

❒ CSUEB, Student Health & Counseling Services *(address above)*

❒ Other:

Name: ______________________________

Address: ______________________________

City: ______________________________

State, Zip ______________________________

Phone: ________________ Fax ______________

Purpose of this release or information exchange:

❒Continuity of Care ❒Billing & Bill Payment

❒Other: ______________________________

I authorize release **TO**: *(Name of **receiving** party)*

❒ CSUEB, Student Health & Counseling Services *(address above)*

❒ Self (Patient listed above) ❒ Other:

Name: ______________________________

Address: ______________________________

City: ______________________________

State, Zip ______________________________

Phone: ________________ Fax ______________

❒ Please mail the records

❒ Please fax the records

❒ I will pick up the records

Specific dates of treatment (if applicable): ____________________ Please check all boxes below for information to be released:

❒ General Medical Records Signature:______________________________ Date:____________

❒ Counseling/Psychiatric Records* Signature:______________________________ Date:____________

❒ Drug/Alcohol Treatment Signature:______________________________ Date:____________

❒ HIV Test Results Signature:______________________________ Date:____________

❒ Other:______________________ Signature:______________________________ Date:____________

Please note: All mental health records will be reviewed by a mental health provider prior to release after direct contact is made with the patient. Records involving HIV testing, mental health counseling or alcohol and drug abuse information will be removed from <u>ALL</u> records without signature to release each as requested above.

My consent may be revoked at any time. Unless previously revoked, this consent will terminate six months after the date of my signing this consent. Each disclosure requires an additional signed authorization. Only original signed requests are valid. I understand the copy fee is $6.00 plus 10 cents for each page copied.

______________________________ ______________

Patient or Parent/Guardian Signature *(If patient is under 18)* Date

Relationship to patient: ______________________________

<u>Office Use Only</u>

ID Verification by: ____________________

Fees Due: ________ Collected:________

Approved by: ____________________

Processed by: ____________________

C/P Withdrawal: Y__ N__ by:_________