SJSU | STUDENT WELLNESS CENTER

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Authorization for Release of Information/Records

Completing this form authorizes the Student Wellness Center (SWC) to release information and health care records to the person/agency indicated below.

Client/Patient Information

Name: _____ Student ID#:_____ Date of Birth:_____

Email:_____ Phone:_____

Person/Agency for Disclosure

Information and records may be released to and/or exchanged with:

Name Person/Agency:_____ Phone of Person/Agency: _____

Email of Person/Agency: _____ Fax of Person/Agency: _____

Address of Person/Agency: _____

Information Parameters

Purpose of Disclosure:

- ☐ Continuing Care / Transfer of Care
- ☐ Follow-up
- ☐ Accommodation Interventions
- ☐ Legal/Court Action
- ☐ Other:_____
  _____

I authorize the release and/or exchange of information as noted below:

- ☐ Health Services
- ☐ Counseling Services
- ☐ Psychiatric Services
- ☐ Other:_____
  _____

Please check the appropriate box(es) indicating the information you wish to release and/or exchange. Please be as specific as possible:

- ☐ Appointment Verification
- ☐ Consultation
- ☐ Diagnostic Information
- ☐ Diagnostic Test Reports
- ☐ Discharge Summary
- ☐ History & Physical Exam/Initial Evaluation
- ☐ Lab Reports/Pathology
- ☐ Psychiatric Documentation
- ☐ Other: _____
  _____

Permission to release and/or exchange the following sensitive records

- ☐ Alcohol and/or drug use
- ☐ AIDS/HIV-related diagnosis
- ☐ Mental Health
- ☐ Permission to release all records

Method of Delivery:

- ☐ SWC Patient Portal Message
- ☐ Secure Email
- ☐ Fax
- ☐ In Person Pick Up
- ☐ Communication via Telephone/Video

Client Consent/Signature

I authorize this release as indicated above. I understand and acknowledge that:

- This authorization remains in effect a maximum of one year from signature unless indicated differently in the box below.
- This authorization may be revoked in writing at any time, except to the extent information has already been released. Any revocation will be confirmed and communicated to authorized individual(s).
- I do not authorize re-release of this information to anyone. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient which is beyond our control.
- A photocopy of this authorization will be treated in the same manner as the original.
- If I do not sign this authorization, the party needing the information may be limited in providing the care, accommodation or other services requiring this information.

Client Signature _____ Date _____

OFFICE USE ONLY

Reviewed by:_____ Date:_____

Additional Information/Notes: