SANTA ROSA JUNIOR COLLEGE

STUDENT HEALTH SERVICES

Santa Rosa - Phone (707) 527-4445 FAX (707) 524-1858
Petaluma - Phone (707) 778-3919 FAX (707) 778-3901

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____
Last Name *First Name* *M.I.*

SSN# ____/____/____ **Birth Date:** ____/____/____

Address: _____
Street, City, Zip Code

' _____ *Home* ' _____ *Work* ' _____ *Cell/Pager*

I, the undersigned, hereby voluntarily authorize the exchange of information between the following providers and/or the authorized representatives of the following agencies/organizations as indicated. I understand that if the organization/agency authorized to receive the information is not a health care provider, Federal Privacy Regulations may no longer protect the released information.

£ To £ From £ Ongoing Exchange

Santa Rosa Junior College
Student Health Services
1501 Mendocino Ave., Santa Rosa CA 95401
Attention: _____

£ To £ From £ Ongoing Exchange

_____
_____
_____
_____
_____

Please supply the following information, with the designated restrictions if applicable:

£ Complete Health Record **From (date)** ____/____/____ **To (date)** ____/____/____

£ All records as they pertain to _____
Specified Condition

£ Immunization Records only

£ All records related to Athletic clearance, participation and injuries only.

£ Other _____

Sensitive Information Release

£ Do not release any sensitive information.
£ I give permission to release information related to treatment for Alcohol and/or drug abuse.
£ I give permission to release information related to AIDS and/or HIV infection.

(By law, a separate authorization form is required EACH TIME information on AIDS and/or HIV infection is released)

This exchange of information is for the purpose of providing effective evaluation, treatment and appropriate services. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked in writing, this authorization will expire on the following date or under the following condition(s): _____.
I further understand that the information provided to Student Health Services is going to be kept CONFIDENTIAL and is protected by Federal Privacy Regulations. I also understand that Student Health Services is not responsible for any mishandling of my information by other agencies/organizations whom I authorize the release to.

Signed: _____ **Date:** _____ **Witness:** _____
Patient, Parent or Legal Guardian if minor

White – Original *Yellow – Student Health Services* *Pink – Patient's Copy*