This form is to be completed by the patient.

I hereby authorize the following individual/entity to release my health information to the Student Health Center at Cal State LA.

Name/Entity: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

Records to be released:

☐ Medical records pertaining to_____ on or about _____.

☐ Physical examination completed on or about _____.

☐ Mental Health Records: _____.

☐ X-Ray films and/or report of _____ taken on or about _____.

☐ Laboratory test results _____.

☐ Other: _____.

Purpose for which the information may be used:

☐ Medical ☐ Education ☐ Personal ☐ Employment ☐ Legal ☐ Other: _____

This authorization is valid through: _____.

Records are to be ☐ mailed ☐ faxed to: Student Health Center - Cal State LA (Attn to: _____)
5151 State University Drive Los Angeles, CA 90032
Phone: 323-343-3337 Fax: 323-343-6557

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily. Treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand my personal health information disclosed under this authorization might be re-disclosed by the recipient, and my disclosed personal health information may no longer be subject to federal or state privacy laws protecting health records.

Name: _____ Signature: _____

Address: _____ City/State/Zip: _____

Phone: _____ CIN: _____

Student Health Center

REQUEST AND AUTHORIZATION FOR HEALTH INFORMATION 3.2025

Last Name: _____

First Name: _____

CIN: _____