Student Wellness Services
Authorization for Disclosure of Protected Health Information

I authorize La Sierra University, Student Wellness Services to ☐ Send ☐ Receive ☐ Exchange (send and receive) to:

Name of individual/organization: _____ Fax: _____

Mailing Address: _____ Phone: _____

Email*: _____

*Please be advised that electronic transmission of information is **NOT** guaranteed to be secure. It is **NOT** advised to request that **SENSITIVE** records be transmitted in this way.*

The type of records and dates of service to be released or disclosed is as follows, check all that apply:

- ☐ Radiology Report (x-ray, ultrasound, CT/MRI, etc)
- ☐ Laboratory Reports (blood test results, urine tests results, etc)
- ☐ Immunization Records
- ☐ TB Skin Tests
- ☐ I specifically authorize release of HIV test results and treatment.
- ☐ Medical Records from _____ to _____
- ☐ Specific Injury/Treatment from _____ to _____
  - ↳ Specify injury:_____
- ☐ Psychiatric Records from _____ to _____
- ☐ Counseling Summary
- ☐ Counseling Attendance
- ☐ Other: (please describe as specific as possible.)_____

Purpose of use/disclosure: This information will be used for the following purpose(s):

☐ Personal Access ☐ Continued Care ☐ Other (please specify): _____

Authorization Statements/Signatures:

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. Unless otherwise revoked, this authorization for the release of health care information to the above-named individual/organization will expire on the date specified below, event identified, or 12 months from the date signed. Date: _____
4. I understand that La Sierra University Student Wellness Services will not condition the provision of treatment or payment on the provision of this authorization.
5. I understand that I have a right to receive a copy of this Authorization if I so request.

_____ _____ _____
Signature of Patient or Personal Representative | Print Name | Date

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

La Sierra University, Riverside, CA
Student Wellness Services
Phone: (951)785-2200 Fax: (951)785-2263
11498 Pierce ST, Suite A & B Riverside, CA 92505

Last Name: _____
First Name: _____
ID #: _____
Date of Birth: ____ / ____ / _____
Month / Date / Year