PALOMAR COLLEGE STUDENT HEALTH CENTERS

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

PATIENT/CLIENT

Name: _____
ID#: _____
Address: _____
Telephone: _____
Date of Birth: _____

INDIVIDUAL/ORGANIZATION AUTHORIZED TO MAKE DISCLOSURE

Name: _____

Palomar College Student Health Centers
1140 West Mission Road
San Marcos, CA 92069
Phone: 760-891-7530
Fax: 760-891-3355

INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL/ORGANIZATION

Name: _____
Organization: _____
Address: _____
Telephone: _____
Secured Fax #: _____

THIS AUTHORIZATION PERMITS THE RELEASE OF THE FOLLOWING INFORMATION

- ☐ Physical Examination Forms
- ☐ Interpretation of Images (Radiology, Ultrasound, CT Scan, MRI, etc.)
- ☐ Physician/Nurse Practitioner Notes
- ☐ Nursing Notes
- ☐ Immunization Records
- ☐ Lab Results
- ☐ Records including Consultations
- ☐ HIV/AIDS Blood Test Results – any/all references to these results

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☐ Billing Records
☐ Behavioral Health (specify)_____
☐ Other (specify)_____

I authorize the release of the information described above for the following purpose(s):
_____
_____

The specific uses and limitations on the types of information to be released are as follows:_____
_____

The specific uses and limitations on the use of the information by RECIPIENT are as follows:_____
_____

- I understand that my health care and the payment for my health care will not be affected by signing this form.
- I understand that I may receive a copy of the information described on this form after I have signed the Authorization.
- I understand that I may revoke this Authorization at any time by notifying Palomar College Student Health Center in writing.
- I understand that this Authorization will expire on:_____

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

Signature_____

Legal Representative_____
Relationship _____

Date _____