Caltech

STUDENT WELLNESS SERVICES
1239 Arden Rd., Mail Code 1-8, Pasadena, CA, 91125
Phone: (626) 395-8331 | Fax: (626) 585-1522

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Name:	
Date of Birth:	Caltech UID:
Address:	
Phone:	Email Address:

I, the undersigned, authorize Caltech Student Wellness Services to obtain, disclose, or exchange my health information as detailed below:

☐**Obtain record(s) from**: ☐**Release record(s) to:** ☐ **Exchange verbally with:**

Name:	
Address:	
Phone:	Fax:

Purpose of Disclosure: I authorize the release/exchange for the following purpose(s):

☐ Personal Use ☐ Continuation of Care ☐ Coordination of on-campus services
☐ Transfer of Care ☐ Other (specify): _____

Health Information Authorized to be Released: I authorize the release/exchange of the following health information:

☐ **Counseling /** ☐ **Psychiatry /** ☐ **Occupational Therapy - select department and record(s):**

☐ Treatment Summary ☐ Attendance ☐Treatment Recommendations

☐ Entire Record

Health; select record(s):

☐ Immunization Records ☐Radiology Report ☐ Laboratory Results

☐ Other (specify): _____

☐ ENTIRE HEALTH RECORD (This may include incidental drug/alcohol and behavioral health information documented by a primary care, urgent care, or specialty provider. You may request excluding any visit note containing this information, which will result in the releasing of only a limited set of records. Entire Health records do **NOT** include counseling, psychiatry, or occupational therapy records—these must be selected separately above.

Specific Authorization:

The following information will **NOT** be released unless you specifically authorize it by initialing the relevant line(s) below:

_____I specifically authorize the release of **mental health, counseling, and/or psychiatric** records.

_____I specifically authorize the release of **HIV/AIDS test results**. *(Cal. Health & Safety Code § 120980 (g))*

_____I specifically authorize the release of **genetic testing information**. *(Cal. Health & Safety Code §124980(j))*

_____I specifically authorize the release of **health information related to sensitive services**, including **abortion and abortion-related care**, with any individual or entity in another state. *(Cal. AB 352)*

I acknowledge that:

1. I can revoke this Authorization at any time.
2. My revocation is not effective for disclosures already made and actions already taken while this Authorization was in effect.
3. Treatment or other benefits are NOT dependent on my signing this Authorization.
4. I am authorizing disclosure of information protected under federal and/or state law. Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure, in some cases, may not be protected by state and/or federal law. Please note that if you wish to impose restrictions on the recipient's use of health information, you must contact the recipient directly.
5. A photocopy or facsimile of this authorization shall be valid as the original authorization.
6. I am entitled to receive a copy of this authorization.

Term and Expiration of Authorization:
Unless otherwise revoked, this Authorization is effective immediately and shall remain in effect until _____. If no date is indicated, this Authorization will **expire twelve (12) months** after the date of requestor's signature below.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name of Signatory

Please select your preferred method to receive records:

☐Paper copy (in-person pickup or mail) ☐Electronic delivery (available for enrolled students only)