Santa Clara University #ID_____ AGE___ DOB_____
Student Medical Services
500 El Camino Real, Building 701
Santa Clara, CA 95050
408.554.4501 | 408.554.2376 fax

STUDENT HEALTH SERVICE MEDICAL RELEASE OF RECORDS AUTHORIZATION

I, _____, understand that my health information is protected by
(Full name) federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (FERPA) and may not be disclosed without either my authorization under HIPAA or my consent under FERPA. I hereby authorize and indemnify the release or disclosure of my protected health information as described below:

1. AUTHORIZATION:

I authorize Santa Clara University, its physicians, and health care personnel, to release or disclose the following PROTECTED HEALTH INFORMATION TO BE DISCLOSED:
(please initial to confirm)

_____ Health Records: Primary, Emergency, X-ray, Diagnostic imaging, Lab, Vaccines, and/or consultation reports

_____ Communicable Diseases (i.e. STD's, hepatitis, COVID-19) **HIV results** ☐ **Yes**

_____ Alcohol/drug abuse

_____ Other (Psychological)_____

2. RELEASE OR EXCHANGE INFORMATION:

☐ **Release my health records to: SCU Student Medical Services Fax: 408-554-2376**

☐ **All past, present, and future periods of healthcare information may be shared.**

☐ **Exchange information with: (Parents, provider, advocate, etc.)**

To: Name: _____ Address: _____

Phone :_____☐Cell ☐ Landline

☐ **Release for this visit dated _____only.**

3. ACKNOWLEDGMENT

By signing this form, I understand that I sign this release or disclosure is voluntary and is not mandatory, and know that I may revoke this waiver at any time in writing. If release happens prior to revocation, I understand that such revocations may not be taken back. Under HIPAA privacy standards, I understand that records re-disclosed to other parties who are not a party to this agreement are prohibited and they must complete a new release form. I understand that upon submission of this release I may have access to these record(s) received in a time-from of 7-10 business days.

_____ _____ _____

Signature Printed Full Name Date Signed

Student Contact phone # _____