Pasadena City College
Student Health Services
1570 E. Colorado Blvd., D-105
Pasadena, California 91106 | (626) 585-7244

Authorization to Release Health Information

Patient:

______________________________ ______________________________
Last First MI Birth Date 8-digit PCC ID

______________________________ ______________________________
Street Address City, State, Zip Code

Contact Number(s): ______________________________

Authorizes:

____
Institution

____
Street Address

____
City, State, Zip Code

Release of Information to:

____
Patient's Name or Institution

____
Street Address

____
City, State, Zip Code

Information to be Released: (Check all that apply)

- ☐ Immunizations ☐ Titers ☐ Program Clearance ☐ Transfer Requirements
- ☐ Chart Notes from: ________________ to ________________
- ☐ Release of information to : ☐ DSP&S ☐ Campus Police ☐ Instructor regarding the following:

____

- ☐ Other: ______________________________

Medical records from outside agencies will not be released. You will need to contact the original agency to obtain copies.

Purpose for Disclosure: (Check all that apply)

- ☐ Personal ☐ Employment ☐ Coordination of treatment/care
- ☐ Other: ______________________________

I am advised of, and understand that:

- I, or my authorized representative or guardian, authorize the disclosure of the above checked medical record(s).
- A copy of this form is as valid as the original.
- I have the right to receive a copy of this authorization upon request.
- I have the right to refuse to sign this form and it will not affect my ability to obtain treatment.
- Any disclosure carries the potential for unauthorized re-disclosure and the information may no longer be protected by federal or state confidentiality laws.
- I have the right to revoke this authorization at any time upon my written request. I will need to update the Authorization to Release Health Information by signing, dating and writing "Revoke" in the section labeled "For Revocation Only" and take it to D-105. If I am unable to go in person, I can mail a copy to the address listed above or I can fax a copy to (626) 585-7933. The copy I fax or mail will need to include my signature, the current date, and the word "Revoke" written in the section labeled "For Revocation Only". Revocation will not apply to information that has already been disclosed in response to this authorization.

Print Name: ______________________________ Signature: ______________________________ Date: ________________
Patient Name or Authorized Representative/Guardian Patient Name or Authorized Representative/Guardian

Relationship to Patient (if applicable)______________________________

For Revocation Only

Print Name: ____________________ Signature: ____________________ Date: ____________ Revoke: ____________
Patient Name or Authorized Representative Patient Name or Authorized Representative Write the word Revoke Here

Office Use Only

Identification:

Type: ____________________ ID#: ____________________ Exp. Date: ________________

Verified By: ______________________________ Date: ________________
Print Name Signature

Delivery Method

- ☐ In-Person
- ☐ Fax
- ☐ U.S. Mail
- ☐ Other:

____

Date: ____________

Dev: 12/15 Rev. 6/20 White Copy – Student Health Services Yellow Copy – Student