SACRAMENTO STATE
Student Health & Counseling Services
6000 J Street, Sacramento, CA 95819-6045
(P) 916.278.6461 | (F) 916.278.7359 | www.csus.edu/hlth

AUTHORIZATION FOR EXCHANGE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client/Patient Name: _____

ID: _____ Date of Birth: _____

Purpose of this disclosure: _____

(Examples: Coordination of Care, Evaluation, Academic Support, Documentation, Referral)

I authorize Student Health & Counseling Services (SHCS) to disclose/exchange information contained in my medical record between SHCS AND:

Name: Patricia Jackson **Organization/Agency:** University Enterprises Inc. Human Resources

Address: 6000 J St., Bookstore Bldg., Ste. 3900 **City:** Sacramento **State:** CA **Zip:** 95819

Phone/Fax: 916.278-5444/916.278-4787

Information released/requested confined to the following:

Counseling, Psychological & Psychiatric Services

- ☐ Courseload Reduction Information
- ☐ Financial Aid Appeal Letter Information
- ☐ Psychological & Counseling Evaluations & Progress Notes
- ☐ Psychiatric Progress Notes, Evaluation & Medication Reports
- ☐ Lab Reports/Tests
- ☐ Psychological Testing Reports
- ☒ Verification of Treatment
- ☐ Entire Record

Health Services

- ☐ GYN Exam
- ☐ Physical Exam
- ☐ Health History
- ☒ Treatment Notes
- ☐ Immunization Records
- ☐ X-Ray Reports
- ☐ Lab Reports/Test
- ☐ Entire Medical Record

Date(s): _____

Information and records requested may contain references to: HIV/AIDS status, alcohol/drug abuse and/or dependence, mental health and sexual assault.

HIV/Aids Status
- ☒ **I DO want it included**
- ☒ **I DO NOT want it included**

Alcohol/Drug Abuse or Dependence
- ☒ **I DO want it included**
- ☒ **I DO NOT want it included**

Mental Health & Sexual Assault
- ☒ **I DO want it included**
- ☒ **I DO NOT want it included**

This authorization automatically expires in 90 days unless otherwise indicated.

Other Date/Event: _____

This information is intended only for the named recipient herewith. It may not be given to another individual or agency without the patient's consent. This authorization will expire 90 days from the date below. I understand that I may revoke this authorization and **must do so in writing**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, except when such disclosure may be a severe detriment to patient/client welfare. The patient may request to review Counseling and Psychiatric records with his/her provider as provided by CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact Student Health & Counseling Services Medical Records Coordinator.

_____ _____

Signature Date

_____ _____

Signature (Parent/Guardian) If Applicable Date