Saddleback College Student Health Services

28000 Marguerite Parkway
Mission Viejo, CA 92692

Phone: 949-582-4606

Fax: 949-582-4227

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patients Name

Local Phone Number

SC ID#

Date of Birth

Release Records From:

Release Records To:

Name:

Name

Agency

Agency

Phone

Phone

Fax

Fax

Address

Address

I request and authorize **Saddleback College Student Health Center** to release the information specified below to the agency, organization or individuals named on this request. ***(Check all that apply)***

Complete Health Record ☐

Laboratory Tests ☐

Psychological/Mental Health Summary ☐
(allow 4-6 weeks for completion)

Progress Notes ☐

Immunization Records ☐

Other ☐
Please specify Below

Explain Other

Covering the period of healthcare **From (Date):** **To (Date):**

The reason I am requesting this information is:

Patient Rights:

I certify that this request has been made voluntarily. I understand that information about my case is confidential and protected by state and federal law. I understand this authorization will **EXPIRE 180 DAYS** from the date of my signature. I may revoke this authorization by writing a letter to the releasing office/health center. I f I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office/health center discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I understand what this agreement means, and that I am entitled to a copy of this form. A copy or fax of this release is as valid as the original.

Copies of PHI records are eligible for release within 30 days after receipt of the provided written request form. For details regarding your rights as a patient please review "Your Rights" section of the *Notice of Privacy Practices*.

Patient Signature **Today's Date**