



Saddleback College • Student Health Services
28000 Marguerite Parkway, Mission Viejo, CA 92692 Telephone 949-582-4606 • Fax 949-582-4227

Authorization to Release Personal Health Information/Medical Records
***From* Saddleback College Student Health Services**

Patient Name: _____ DOB: _____

I authorize Saddleback College Student Health Services/ _____ to release my
(Physician, Psychologist, or RN)
personal health information, with the following limitations:

to: _____ (Name) _____ (Relationship to patient)
_____ (Mailing Address) _____ (Telephone/FAX Number)

This authorization will remain in effect until _____.

Patient Signature: _____

Parent/Guardian/Conservator Name: _____

Parent/Guardian/Conservator Signature: _____

Date: _____ Witness: _____

***To* Saddleback College Student Health Services**

Patient Name: _____ DOB: _____

I authorize _____ to release
my personal health information, with the following limitations:

to Saddleback College Student Health Services/ _____
(Physician, Psychologist, or RN)

This authorization will remain in effect until _____.

Patient Signature: _____

Parent/Guardian/Conservator Name: _____

Parent/Guardian/Conservator Signature: _____

Date: _____ Witness: _____

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