Medicat ID # _____

Mt. San Jacinto Community College
Student Health Services (SHS)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name (PRINT): _____ Date of Birth: _____

Previous Names (PRINT): _____ Student ID #: _____

I, _____ request and authorize Mt. San Jacinto Community College Student Health Services to release healthcare information of the patient named above to:

☐ SELF ☐ THIRD PARTY / OTHER PERSON / FACILITY

Facility (PRINT): _____

Name (PRINT): _____

Title (PRINT): _____

Address (PRINT): _____

_____

Phone:_____ Fax: _____

This request applies to:

TYPE OF DISCLOSURE: ❑ Copies ❑ Verbal ❑ Summary ❑ Letter

☐ ALL HEALTHCARE INFORMATION including but not limited to treatment, condition, counseling, diagnosis, prescriptions and lab work.

☐ SPECIFIC HEALTHCARE INFORMATION relating to: _____

_____

_____

HEALTH INFORMATION YOU AUTHORIZE TO BE RELEASED: ❑ Medical ❑ Mental

DATE(S) OF TREATMENT: _____

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. 2.34 and 2.35).

☐ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code 120980(g)).

☐ I specifically authorize the release of genetic testing information (Health and Safety Code124980(j)).

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The purpose of this release is for:

CHECK ONE OR MORE: ❑ At the request of the patient/patient representative

❑ Other (state reason)_____

NOTICE

SHS and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal laws.

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to one of the three (3) SHS campus locations:

1499 N. State Street, Modular 1540, San Jacinto, CA 92583
28237 La Piedra Road, RM 723, Menifee, CA 92584
41888 Motor Car Parkway, RM TBD, Temecula, CA 92591

The revocation will take effect when SHS receives it, except to the extent SHS or others have already relied on it.

You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date). If no date is indicated, the Authorization will expire ninety (90) days after the date of signing this form.

Printed Name: _____ Signature:_____

Relationship to Patient: _____ Date/Time:_____
(Parent, Guardian, Conservator, Patient Representative)

Witness: _____
(only if patient unable to sign) or Interpreter

❑ **San Jacinto Campus**
1499 N. State St., Modular 1540
San Jacinto, CA 92583
(951) 487-3206

❑ **Menifee Valley Campus**
28237 La Piedra Rd., Room 723
Menifee, CA 92584
(951) 639-5206

❑ **Temecula Valley Campus**
41888 Motor Car Pkwy., TBD
Temecula, CA 92591
TBD

Revised 10/21/2020