Santa Clara University
Cowell Center Student Health Services
500 El Camino Real, Building 701
Santa Clara, CA 95050
408.554.4501 | 408.554.2376 fax

STUDENT HEALTH SERVICE MEDICAL AUTHORIZATION TO RELEASE RECORDS

I, _____, date of birth _____, age _____, understand that my health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (FERPA) and may not be disclosed without either my authorization under HIPAA or my consent under FERPA. I hereby authorize and indemnify the release or disclosure of my protected health information as described below;

1. AUTHORIZATION:

I authorize Santa Clara University, its physicians, and health care personnel, to release or disclose the following PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

(please initial to confirm)

_____ Health Records: Primary, Emergency, X-ray, Diagnostic imaging, Lab, Vaccines, and/or consultation reports

_____ Communicable Diseases (i.e. STD's, hepatitis, COVID-19) **HIV results** ☐ **Yes** _____

_____ Alcohol/drug abuse **Initials**

_____ Other (Psychological)_____

2. RELEASE OR EXCHANGE INFORMATION:

☐ **Release my health records to: SCU Cowell Health Services Fax: 408-554-2376**

☐ **All past, present, and future periods of healthcare information may be shared.**

☐ **Release only:** _____

☐ **Exchange information with: (Parents, provider, advocate, etc.)**

To: Name: _____ Address:_____

Fax: _____ Phone :_____

3. ACKNOWLEDGMENT

By signing this form, I understand that I sign this release or disclosure is voluntary and is not mandatory, and know that I may revoke this waiver at any time in writing. If release happens prior to revocation, I understand that such revocations may not be taken back. Under HIPAA privacy standards, I understand that records re-disclosed to other parties who are not a party to this agreement are prohibited and they must complete a new release form. I understand that upon submission of this release I may have access to these record(s) received in a time-from of 7-10 business days.

_____ _____ _____

Signed Printed Name Student #

Date Signed _____ Contact phone #_____

Optional: _____

Expiration Date NAME-RECORDS RELEASED BY_____