COLUMBUS STATE UNIVERSITY

Student Health Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize release of information from the **Medical Record** of:

Patient Name: _____ Date of Birth: _____

(Please Print)

Social Security last 4 #: _____ CSU ID#:909_____ Daytime Phone #: _____

Release Information To:

_____

_____

_____

Request Information From:

_____

_____

_____

Please Release the following: (please check)

☐ Lab Reports
☐ Immunizations
☐ Other Diagnostic Reports **(specify tests and dates)** _____
☐ Other **(specify)** _____

Purpose of need for disclosure:

☐ Personal Use
☐ Continued Health Care with other Provider
☐ Other **(specify)** _____

Please check one:

☐ I will pick up copies myself (allow 24 hours)
☐ Please mail copies to the address listed above
☐ **Fax** copies to 706-568-2323
☐ **Fax** copies to _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent in writing at any time. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____ _____
Relationship to Patient Witness Date

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold Columbus State University Student Health Center liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____ _____
Relationship to Patient Witness Date

FOR OFFICE USE ONLY:

Date request completed: _____ #copies copied: _____ Initials: _____

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