California State University
SAN MARCOS

Student Health & Counseling Services California State University San Marcos 333 S. Twin Oaks Valley Road San Marcos, CA 92096-0001
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CONSENT TO RELEASE MEDICAL RECORDS

Patient name:_____ Telephone Numbers:

Date of birth:_____ Cell: _____

Student ID #:_____ Home/Other:_____

I hereby authorize and request that _____
Name of facility/individual

_____
Address City/State/Zip

_____
fax number, if applicable

Release information from my records to the following:

Name of the facility/individual:_____

_____
Address City/State/Zip

_____
fax number, if applicable

Please be specific regarding record and dates requested

Information to be released:

- ❑ Diagnosis and record of treatment _____ Specific date/dates requested
- ❑ Laboratory and/or X-ray reports _____ Specific date/dates requested
- ❑ Immunization/ TB test record _____ Specific record and dates given
- ❑ Entire file (excluding confidential and psychiatric records, if any)
- ❑ Other_____

I understand that upon my request, I will be given a copy of the information released. I also understand that there will be a small processing fee for the copy I personally receive. I give my consent to the release of above-mentioned information and understand that my consent is subject to revocation at any time. This ROR will expire 60 days after the date of the signature.

_____ _____
Patient signature Date

Student Health and Counseling Services Use Only

ID verification by_____ ❑ Emailed records to patient (date/time)_____

❑ Faxed (date/time)_____ ❑ Mailed records to patient (date)_____

❑ BCA Records given to patient / date and time_____ Educator's approval_____

❑ Records given to patient / date and time_____ Provider's approval_____

❑ Patient will pick up approximately on: _____ Payment amount:_____ Credit/Debit/Cash

Revised 8/14