De Anza Student Health Services
21250 Stevens Creek Blvd.
Cupertino, CA 95014
Phone: (408) 864-8732 | Fax: (408) 864-8983

AUTHORIZATION FOR RELEASE/DISCLOSE OF HEALTH INFORMATION

Patient Information:

Name (Last, First, Middle):____

Address: ____

Student ID #: ________________________________**Date of Birth:** ____________________________

Phone: ______________________________________**Email:** _________________________________

Authorization:

I hereby authorize to release/disclose the following information to:

- ○ De Anza College – Student Health Services
- ○ Other:

Recipient Name or Facility: ____

Address, City, State and Zip code: ____

Phone: _________________________________ Fax: ___________________________________

Health Information to be released/disclosed (Select the records below):

- ☐ Immunization Records **ONLY**
- ☐ All Lab/Diagnostic Test Results **OR** pertaining to the following dates/diagnosis (please specify):____
- ☐ All medical records **OR** pertaining to the following dates/diagnosis (please specify):____
- ☐ Others (please specify): ____
- ☐ HIV test results dated from: __________________________ to: ________________________
  - ○ Required Signature: __________________________________ Date: ______________

Purpose: I authorize the release/disclose of my health information for the following specific reasons:

____

To receive the records by (select one option):

- ○ **Mail (Certified)**
- ○ **Fax to:** ______________________________ **Must include a phone number for us to call to verify**

  Fax number:______________________________________
- ○ **Pick up by patient.** **Bring a picture ID**

  A picture ID MUST be provided. The name must match what is listed on this form

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Patient Name: ____

Student ID #: ___________________________ **Date of Birth:** _______________________

Please be prepared to provide a copy of photo identification upon request.

- **Releasing records to self:** As the person signing this authorization, under FERPA, if the school release health records for the purposes other than treatment, the records will then be considered "education records" and are subject to all other FERPA requirements. I understand that by receiving my health information records personally from De Anza Student Health Services and not through a third party (i.e. primary care provider), my health information records will now be considered education records and will no longer fall under the protection of HIPAA privacy rules. Upon agreeing to this, I understand that this action cannot be revoked or changed anytime.
- **As the person signing this authorization:** I understand that I am giving my permission to De Anza College Student Health Services for disclosure of confidential health records. A copy of this authorization shall be included with my original health records.
- **Redisclosure:** I understand that health information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of De Ana College Student Health Services.
- I also understand that I have the right to revoke this authorization any time and have all the right to refuse to sign this form (except to the extent that information has already been released or if the health records have become education records).

EXPIRATION DATE: is automatically expire 1 (one) year from date signed, unless earlier date, condition or event is indicated.

____ ___________________________

SIGNATURE of Patient or Authorized Representative **Date of Signature**

FOR STUDENT HEALTH SERVICES USE ONLY

FORM SUBMISSION:
Name of Patient or Authorized representative with ID verified:

____

Verification of Authority: ____________________________ Expiration Date: ___________________________

RECORD REVIEW: Records have been reviewed by: ________________________Date: ___________________

RECORD DELIVERY:

☐ Faxed # ______________ ☐Fax # confirmed ☐Mailed ☐Certified Mail

☐ Picked up by patient **OR** ☐ Picked up by authorized recipient | ☐ paper **OR** ☐ electronic

PHOTO ID verified by: ____

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