AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

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

Patient Information:

Patient Name: ____

Date of Birth: ____________ Student ID: ________________

Address: ____

Phone: ____________________ Email: ____________________

Delivery Method:

☐ Mail Fax Pick-up

Purpose:

☐ Continuity of care ☐ Patient copy ☐ Other: ________

Administrative Review (*Fill out page 2)*

Authorization: I hereby authorize:

☐ De Anza College – Student Health Services

☐ Other: ____

To release medical information to: ☐ **Self** ☐ **Other: (Provide info below)**

Name / Facility: ____

Address: ____

Phone: ______________ Fax: ____________ Email: ______________

Information to be released:

☐ All Medical Records
☐ Immunization Records
☐ Laboratory / Diagnostic Procedure Results
☐ Other: ________________

Date Range: ________________

Note: Any mental health/psychological evaluation or substance abuse-related information will not be included.

*****All requests must be accompanied by a photo ID of the patient.**
*****If an individual other than the patient is picking up the records, then that individual must have the original signed request and a photo ID.**
*****Please allow 5-7 business days for the request to be processed.**

Reviewed: 12/2018

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ADMINISTRATIVE RELEASE / REVIEW	
Staff / Faculty Name:	
Position / Title:	
Reason for Access:	
Signature / Date:	

Signature of Patient: ________________ **Date: __________________**

DAHS Staff Initials: ____

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*****If an individual other than the patient is picking up the records, then that individual must have the original signed request and a photo ID.**
*****Please allow 5-7 business days for the request to be processed.**

Reviewed: 03/2018