TOURO UNIVERSITY
CALIFORNIA
Student Health Center

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: ______________________ DOB: ________ Phone: ________ Program: ________

Address ______________________ City: __________ State: ________ Zip: __________

Purpose of requested use or disclosure:

- ☐ Continuity of Care
- ☐ Patient
- ☐ Health Care Provider

Delivery Method Requested:

- ☐ Electronic/Uploaded to E-value
- ☐ Pick Up
- ☐ Mail
- ☐ Secure Fax

I hereby authorize

TUCA Student Health Center
(Name of hospital, physician, healthcare provider)

1310 Club Dr. Building H-89, suite 1537 Vallejo, CA 94592
Address City, State Zip

707-638-5220 707-638-5261
Phone number Fax number

To release my information to:

____
(Name of hospital, physician, healthcare provider)

____
Address City, State Zip

____
Phone number Fax number

Information to be released:

- ☐ Complete medical record
- ☐ History and Physical (most recent)
- ☐ Consultation
- ☐ Emergency Physician Report
- ☐ Laboratory/Radiologist report (s) specify: ______________________
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Current PPD
- ☐ Vaccinations/Other: ______________

Expiration: This authorization shall become effective immediately and shall remain in effect for one year from the date signed unless a different date is specified here: ________________

Restrictions:
California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:

Student Health Center
Touro University California
1310 Club Drive, Building H-89, Suite 1537
Vallejo, CA 94592 P: 707-638-5220 F: 707-638-5261

- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure.

Signature: ______________________ **Date:** ____________ **Time:** ________

SHC Use:

Completed by: Date: