



Student Health Center
Request/Authorization for the Release of Protected Health Information

Last Name First Middle DOB SSN/Banner ID

Other Name(s) Used:

Phone No. Cell No.

Student Faculty Classified Other

Date(s) of Visit for record(s) being requested: Fall Spring Summer Year Year Year

Please Note:

Planned Parenthood Medical Records: Available on Wednesday/Thursday ONLY
Health Center Medical Records: Same Day/Next Day - if Record(s) within year

- I am requesting Same Day Pick-Up \$5.00 (Cash Only)
I am requesting Next Day Pick-Up \$3.00 (Cash Only)
Please mail my Medical Records to Address Listed on "Authorization for the Release of Protected Health Information" (PHI)

In my absence, I authorize the release of my Protected Health Information to
I understand that a valid California Driver's License and/or State ID needs to be shown by me or authorized/designated person at the time of delivery of the PHI Records.

Signature Date

OFFICE USE ONLY

Request Processed By: Record(s) Unavailable

Date Issued to Student:

Signature/Received PMI: