SANTA MONCA COLLEGE STUDENT HEALTH SERVICES
AUTHORIZATION TO RELEASE

Office: 310-434-4262 Fax: 310-434-3614

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Name of Student: _____ Date of Birth: _____ Student ID: _____

I, the undersigned hereby authorize the ( ) Disclosure ( ) Exchange of the following Protected Health Information (PHI) between:

Santa Monica College Student Health Services **AND:** Name/Agency _____

1900 Pico Blvd. Address _____

Santa Monica, CA 90405 Phone number: _____

Fax: _____

PURPOSE FOR RELEASE OF PHI:

( ) Aid by the Above-Named Agency ( ) Legal Proceeding

( ) Continued Care by the Receiving Facility/Doctor/Therapist ( ) Other_____

PHI TO BE RELEASED:

( )	Assessments	( )	Diagnosis Only
( )	Medication Records	( )	Progress Notes
( )	**Communications Only***	( )	TB Test
( )	Consultation Reports	( )	Other_____

(*Specify the specific party/agency where oral communication is to be conducted.)

This authorization is effective immediately and subject to revocation at any time, except to the extent that action has already been taken, and shall expire within 365 days from the date of signature.

I understand this authorization is required and I must voluntarily and knowingly sign this authorization prior to any records being released. In the event I refuse to sign the authorization, records cannot and will not be released.

I further release Santa Monica College from any liability arising from the release of information to the person(s)/agency designated above.

I have received a copy of this signed authorization. This authorization shall be terminated when withdrawn, and becomes void on my date of discharge.

A faxed copy can be used as an original. _____ (initials)

_____ _____ _____

Printed name of Student or Responsible Party **Signature of Student or Responsible Party** **Date**

_____ _____

Signature of Witness **Date**