



Pasadena City College
Student Health Services
 1570 E. Colorado Blvd., D-105
 Pasadena, California 91106 | (626) 585-7244

Authorization to Release Health Information

Patient:

 Last First MI Birth Date 8-digit PCC ID

 Street Address City, State, Zip Code

Contact Number(s): _____

Authorizes:

 Institution

 Street Address

 City, State, Zip Code

Release of Information to:

 Patient's Name or Institution

 Street Address

 City, State, Zip Code

 Email Address

Information to be Released: (Check all that apply)

- Immunizations Titters Program Clearance Transfer requirements
- Chart notes from date: _____ to date: _____
- Release information to: DSP&S Campus Police Instructor regarding the following:

- Other: _____

Medical records from outside agencies will not be released. You will need to contact the original agency to obtain copies

Purpose of Disclosure: (Check all that apply)

- Personal Employment Coordination of treatment/care
- Other: _____

I am advised of, and understand that:

- I, or my authorized representative or guardian, authorize the disclosure of the above checked medical record(s).
- A copy of this form is as valid as the original.
- I have the right to receive a copy of this authorization upon request.
- I have the right to refuse to sign this form and it will not affect my ability to obtain treatment.
- Any disclosure carries the potential for unauthorized re-disclosure and the information may no longer be protected by federal or state confidentiality laws.

Print Name: _____ Signature: _____ Date: _____
Patient Name or Authorized Representative/Guardian Patient Name or Authorized Representative/Guardian

Relationship to Patient (if applicable): _____

Office Use Only

Identification Type: _____ ID#: _____ Exp. Date: _____

Verified By: _____ Date: _____
Print Name Signature

Delivery Method: In-Person Fax U.S. Mail Other: _____ Date: _____