Crafton Hills College
HEALTH AND WELLNESS CENTER
11711 Sand Canyon Road, SSB 101
Yucaipa, CA 92399
(909) 389-3272 * FAX: (909) 389-0772

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Birth Date: _____

ID Number: _____

Persons/Organizations providing the information: _____
_____

Persons/Organizations receiving the information: _____
_____

Specific description of information (include dates): _____
_____

What is the purpose of the use or disclosure? _____

I understand that my health care and the payment for my health care will not be affected by my signing this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

I understand that this authorization will expire on _____/_____/_____ (MM/DD/YR).

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

Signature of patient or patient's representative: _____
Date: _____
Printed name of patient's representative: _____
Relationship to the patient: _____
You may refuse to sign this authorization.