UNIVERSITY OF THE PACIFIC

STUDENT HEALTH SERVICES
UNIVERSITY OF THE PACIFIC

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

NOTICE

University of the Pacific and many other organizations and individuals are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on signing or refusing to sign this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan of which the patient is not already a member, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party. This Authorization may be revoked at any time. The revocation must be in writing, signed by the individual on his/her behalf, and delivered to the Privacy Officer, (209) 946-2124, 3601 Pacific Ave, Stockton, CA 95211. The revocation will take effect when Pacific receives it, unless Pacific or others have already relied on it. Immediately upon receipt of a revocation from a student, the Privacy Officer will notify Student Health Services. Pacific must give you a copy of this Authorization. This information is for use only by the recipient named below. It can not be given to any other individual or agency without the patient's authorization. **Information:** The patient must complete this form in its entirety in order for Student Health Services to release any medical information. The patient and/or requesting party must be specific as to the nature of the information he/she would like and the purpose for which this is requested. The patient is entitled to receive a copy of this release.

I authorize: _____
(**Name** of Individual or Agency & Complete **Address**)

_____ - _____ - _____ and _____ - _____ - _____
(Phone) (Fax)

To release to: _____
(**Name** of Individual or Agency & Complete **Address**)

_____ - _____ - _____ and _____ - _____ - _____
(Phone) (Fax)

(1) Records of my treatment for dates beginning _____/_____/_____ and ending on _____/_____/_____

(2) Lab Reports dated: _____

(3) X-ray Reports/Films dated: _____

(4) Immunization Records: _____

(5) Other: _____

(6) For the purpose of: _____

This information can not be given to any other individual or agency without the patient's authorization. **This Authorization expires** _____/_____/_____ If no date or event is specified, this Authorization expires one year from the Date specified below.

PRINTED NAME:_____STUDENT'S SIGNATURE:_____

DATE: _____/_____/_____ PACIFIC ID#:_____ - _____ - _____ DATE OF BIRTH: _____/_____/_____

MAILED FAX GIVEN
(circle one)

3601 Pacific Avenue ▪ Stockton, CA 95211 ▪ Phone: 209-946-2315 ▪ Fax: 209-946-3001