AUTHORIZATION FOR DISCLOSURE OF MY MEDICAL INFORMATION TO STANFORD UNIVERSITY OCCUPATIONAL HEALTH CENTER

IDENTIFICATION

Patient Name: _____
(Please PRINT full name)

SU ID: _____

Date of Birth:_____ Telephone Number:_____

DESIGNATION OF MEDICAL INFORMATION TO BE DISCLOSED TO STANFORD UNIVERSITY OCCUPATIONAL HEALTH CENTER

Please check the applicable medical information to be disclosed to SUOHC:

- ☐ Entire Records
- ☐ Immunization Records Only
- ☐ Following Portions of the Record Only (please specify):_____
- ☐ Laboratory Test Results
- ☐ Check this box to include HIV test results
- ☐ X-Ray Film(s)

RELEASE BY WHOM

I authorize _____, located at (specific contact person and address) _____

To release the medical information specified above to Stanford University Occupational Health Center.
The purpose of the disclosure is: ☐ patient request/ ☐ other: _____
_____

Please indicate the method of delivery:

☐ Please fax the information to: (650) 725-9218

☐ Please mail the information to: Occupational Health Center, 480 Oak Road, Stanford University, Stanford, CA 94305-8007

To the attention of (requesting Occupational Health Center employee): _____

OTHER TERMS OF THE AUTHORIZATION

This authorization shall remain in effect from the date I sign until _____ (specify a date or event upon which it will expire, but no longer than six months).

I understand that: (a) the authorization is subject to revocation at anytime, ***by written notification only to Stanford University Occupational Health Center (SUOHC)*** *(at the address below)*, except to the extent that SUOHC already disclosed the information; (b) the information disclosed may be subject to nondisclosure by the recipient and may no longer be protected; (c) I may refuse to sign this authorization, (d) SUOHC may not condition my treatment upon it being signed; (e) I am entitled to a copy of this authorization.

I agree to pay the fees associated with copying, faxing, and mailing in accordance with my authorization above.

APPLICABLE FEE

The fee for this service is as follows:

□ Entire Chart ($18) Total Due:_____
□ Immunization Record ($7) Total Due:_____
□ Small Specific Portion ($7) Total Completed:_____

SIGNATURE

_____ _____
Signature of Patient or Representative Date

If signed by patient representative provide a description of authority to act for the patient:
_____

Occupational Health Center
480 Oak Road
Stanford University
Stanford, CA 94305-8007