AUTHORIZATION FOR DISCLOSURE OF MY MEDICAL INFORMATION FROM STANFORD UNIVERSITY OCCUPATIONAL HEALTH CENTER (SUOHC)

IDENTIFICATION

Patient Name: ____
(Please PRINT full name)

Date of Birth:________________ Telephone Number:_________________

DESIGNATION OF MEDICAL INFORMATION TO BE DISCLOSED

Please check the applicable medical information to be disclosed:

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

RELEASE BY WHOM

I authorize Stanford University Occupational Health Center, located at 480 Oak Rd., Stanford, CA 94305-8007 to release the medical information specified above to

____

____

The purpose of the disclosure is: ☐ patient request/ ☐ other:

____

Please indicate the method of delivery:

☐ Please fax the information to:

____

☐ Please mail the information to: ______________________________________

____

To the attention of:

____

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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 any time, by written notification only to the holder of the medical information specified above, except to the extent that the holder of the medical information has already disclosed the information; (b) the information disclosed may be subject to redisclosure 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