AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Last Name First Name Date of Birth

_____@my.yosemite.edu
Student Email Address Student ID #

****

I authorize: (Person or facility which has health information)

☒ Modesto Junior College, Health Services
435 College Avenue Modesto, CA 95350
Phone: (209)575-6037 Fax: 209 575-6786
Email: mjchealthservices@mjc.edu

To Release to:

☒ Self

☒ Modesto Junior College, West Campus
Allied Health Division Office
435 College Avenue Modesto, CA 95350

☐ Name:_____
Address: _____
Phone: _____ Fax: _____

☐ Name:_____
Address: _____
Phone: _____ Fax: _____

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Type of Disclosure:

☒ Verbal Information ☒ YCCD Email-Copies of Records ☒ Mailed Copies of Records ☐ Fax

Health information to be released:

☒ All records (This may include drug/alcohol and mental health information documented by a primary care practitioner)
☐ Mental health information (Subject to the Lanterman-Petris-Short Act, Welf. Inst. Code §5000 et seq.)
☐ Lab Reports
☐ X-Ray Reports
☐ Drug and alcohol abuse, diagnosis, or treatment Information subject to federal law (42 C.F.R. §§2.34 and 2.35)
☐ HIV/AIDS test results (Health and Safety Code §120980(g)
☐ Other, if not specified above (e.g. Summary Report,Letter):_____

The purpose of this release is:

☒ At the request of the patient for continuity of care ☐ Other_____

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1. This Authorization will expire in one year from date of signature.
2. I may revoke this Authorization at any time by notifying Modesto Junior College Health Services, in writing or by email, and it will be effective on the date notified except to the extent that MJC Health Services has already acted upon such Authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

Signature of Patient: _____Date:_____

*Select Sign above to add your signature