Stanford Vaden Health Center

VADEN HEALTH SERVICES
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Upon completion of this form, health information you have identified will be released. Be sure to read each section carefully and complete only those that are applicable to your specific needs.

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SECTION A: Identify the patient for whom release of health information is being requested.

Patient's name: Last: _____ First: _____ M: _____

Date of birth: _____ Phone number: _____Student SUID: _____

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SECTION B: Authorize release of health information by selecting the pertinent options below. Some types of health information require separate authorization for release (e.g., HIV test results and certain mental health records). Subsections B.1, B.2, B.3, and B.4 pertain to specific types of releases. **You must both check the box and enter your initials to authorize release of the information described next to the box**.

B.1: <u>General Health Information Release</u> The options in this section pertain to general health information only. **HIV test results and/or mental health records will not be released through selections made in this subsection** (see pertinent sections below).

☐ _____ Check here ***and initial*** next to the box to authorize release of the entire medical record
☐ _____ Check here ***and initial*** next to the box to authorize release of immunization records only
☐ _____ Check here ***and initial*** next to the box to authorize release of laboratory test results only
☐ _____ Check here ***and initial*** next to the box to authorize release of Radiology report(s) only
☐ _____ Check here ***and initial*** next to the box to further describe the health information for release or to identify records not listed above. Provide description: _____
☐ _____ Check here ***and initial*** next to the box to authorize release of information ***indicated above*** for specific dates of service only. Specify dates: _____

B.2: <u>Mental Health Information Release</u>

☐ Check here ***and initial*** on any or all of the lines below to authorize release of records for outpatient mental health services provided by: **Specify Dates:**

_____**Counseling and Psychological Services (CAPS)*** _____
_____**Weiland*** _____
_____**Confidential Support Team (CST)*** _____

**The physician, licensed psychologist, licensed clinical social worker, and/or marriage/family therapist involved in the care may deny release of the information in limited circumstances.*

B.3: <u>HIV Lab Test Results Release</u>

☐ _____ Check here ***and initial*** next to the box to authorize release of results from HIV testing performed at Vaden Health Center. Specify dates: _____

B.4: <u>Non-Treating Physician Access to Electronic Medical Record</u>

☐ _____ Check here ***and initial*** next to the box to authorize the following physician(s) who are not involved in your treatment to access your electronic medical record:

_____

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SECTION C: Indicate the reason(s) for release of your health information.

☐ Patient request ☐ Decline to provide a reason

☐ Other (specify):_____

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SECTION D: Indicate the person (or facility) to whom you authorize release of the health information described on this form. If you wish to impose restrictions on the recipient's use of the health information, you must contact the recipient directly.

Name of person/facility authorized to receive the health information: _____

Address: _____Email: _____

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SECTION E: Please select a method of delivery.

☐ Check here if you would like the health information **mailed** to the recipient's address above.

☐ Check here if you would like the health information securely **emailed** to the recipient's email above

☐ Check here if you would like the health information **faxed** to the recipient indicated above.
Provide the fax number: _____

☐ Check here if you will pick up the requested health information at Vaden Health Center.

☐ Check here if you are requesting only to inspect your records at Vaden Health Center, but do not need copies. A representative from Vaden will contact you to make arrangements.

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SECTION F: Establish an expiration date for this authorization.

This authorization becomes effective upon signing and will expire on _____ (date not to exceed one year). If no date is indicated, this authorization will expire one year from the signature date.

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SECTION G: Privacy Rights

- You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment.
- You have the right to withdraw or revoke this authorization in writing at any time, except to the extent that Vaden Health Center has already released the health information. To withdraw or revoke your authorization, please submit your request in writing to:
  Vaden Health Center, Attn: Medical Records, 866 Campus Drive, Stanford, CA 94305.
- Vaden Health Center may deny your request to inspect and/or receive a copy of your health information under certain circumstances as authorized by law. You will be notified of any such denial and informed of the steps required for appeal.
- You have the right to receive a copy of this authorization.

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SECTION H: Additional Terms and Considerations

- Health information released as a result of this authorization could be re-disclosed by the recipient. Re-disclosed information may no longer be protected by state or federal privacy laws.
- Fees may apply and are due prior to release of information. Applicable fees associated with copying and distributing records are as follows:
  - **Patient directed records request: up to $6.50**
  - **Third party records request: $ 0.25 per page**
- Records released as part of direct treatment do not incur any fees.
- If you have questions about this authorization form or the release of your health information, please contact the Vaden Health Center Medical Records Department at **650-725-6979**.

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SECTION I: Sign and date below to authorize Vaden Health Center to release the health information identified on this form.

Name of patient or legal representative (please print): _____

Address of patient or legal representative (please print):_____

Phone number of patient or legal representative (please print): _____

If you are not the patient and are signing on his/her behalf, describe your authority and provide supporting legal documentation:

_____

_____

Signature of patient or legal representative:

_____ Date: _____

For Vaden Health Services Use Only

Mental Health Records Only: The physician, licensed psychologist, licensed clinical social worker, and/or marriage/family therapist involved in the patient's care has reviewed the record and:

CAPS: ☐ approves request for release ☐ denies request for release (indicate reason below):

Weiland: ☐ approves request for release ☐ denies request for release (indicate reason below):

CST: ☐ approves request for release ☐ denies request for release (indicate reason below):

_____

_____

Signature of reviewer (**CAPS**): _____ Date: _____

Signature of reviewer **(Weiland):** _____Date: _____

Signature of reviewer (**CST**): _____ Date: _____

Administration Review: All denials will be reviewed by Vaden's Privacy/Security official.

Comments:_____

_____

Signature of reviewer: _____ Date: _____

Notification to Requestor: By whom: _____ Date: _____

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Medical Records Personnel: Information must be supplied for all records released.

Description of records released:

Released to:
Distribution method:
Date of release:
By:

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