AUTHORIZATION FOR DISCLOSURE OF MY MEDICAL INFORMATION TO VADEN HEALTH CENTER

IDENTIFICATION

Patient Name: _____
(Please PRINT full name)

First/Last quarter at Stanford:_____ SU ID:_____

Date of Birth:_____ Telephone Number:_____

DESIGNATION OF MEDICAL INFORMATION TO BE DISCLOSED TO VADEN

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

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

RELEASE BY WHOM

I authorize _____, located at (specific contact person and address) _____
_____
to release the medical information specified above to Vaden Health Center.

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

Please indicate the method of delivery:

☐ Please fax the information to: **(650) 723-1600**.

☐ Please mail the information to:

Vaden Health Center
Stanford University
866 Campus Drive
Stanford, CA 94305-8580.
To the attention of (requesting Vaden health care provider):
_____

OTHER TERMS OF THE AUTHORIZATION

This authorization shall remain in effect from the date I sign until _____ (specify a date, but no longer than six months).

I understand that: (a) the authorization is subject to revocation at anytime, ***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) if I have authorized disclosure to someone who is not legally required to keep the information confidential, the recipient may disclose to others; (c) I may refuse to sign this authorization and any refusal will not effect my ability to obtain treatment; (d) I am entitled to a copy of this authorization.

I agree to pay any reasonable fees associated with copying, faxing, and mailing in accordance with my instructions above.

SIGNATURE

_____ _____.

Signature of Patient or Representative Date

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