California State Polytechnic University, Pomona – Department of Athletics
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AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please REQUEST Medical Information FROM:

_____
Name of Health Care Provider

_____
Name of Medical Office/Hospital/Entity

_____
Street Address

_____
City, State, and Zip Code

Please SEND Medical Information TO:

_____
Name of Person or Entity to Receive Information

_____
Title (Physician, Athletic Trainer, Therapist, Attorney, Insurance Co.)

_____
Street Address

_____
City, State, and Zip Code

I hereby authorize _____ (provider or entity name) to release and/or disclose the medical information as indicated below to the health provider, entity or person I have indicated above.

_____ _____ _____
Name of Patient (List other names used in applicable) Bronco ID Number Date of Birth

_____ _____ _____
Address City, State, Zip Code Telephone Number

Duration: This authorization shall become effective immediately and shall remain effective until _____ (enter date) or for one (1) year from the date of the signature if no date is entered.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Re-disclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Release and/or disclose records and information regarding:

Specify records to be released and/or disclosed: Initial which type of information is to be released and/or disclosed. Mark all that apply.

_____ All records and medical information (from _____ to _____)

_____ Only information regarding _____ (injury, condition, treatment)

_____ X-Ray (check one or both) ___ Film/Disc ___ Report for _____ (injury, condition, treatment)

_____ Laboratory Result(s) for _____ (injury, condition, treatment)

_____ Other _____ (specify records to be released or disclosed)

_____ I request that the health information release and/or disclosed pursuant to this authorization be used for the following purposes only:

_____

The signature below authorizes the release of my records as specified above.

_____
Signature of Patient Date

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.