Sierra College Health Services - Rocklin
5100 Sierra College Blvd., Rocklin, CA 95677
Phone: (916) 660-7490 Fax: (916) 630-4545

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I hereby authorize: _____
Name (or title) and organization

_____
Address

_____
City State Zip

to disclose to: _____
Name of recipient

_____
Address

_____
City State Zip

records and information pertaining to: _____
Patient name (list other names used) DOB SSN

_____
Address

_____
City State Zip

Specify records by checking all boxes that apply:

- ☐ Medical information
- ☐ Drug/alcohol information
- ☐ Psychiatric information
- ☐ Health information relating to the following treatment or condition: _____
- ☐ Health information for the date(s): _____
- ☐ Other: _____

I authorize release of my health information for the following purpose(s): _____

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____.
Date

I may revoke this authorization in writing at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this Authorization.

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

I understand that I have the right to:

Inspect and request a copy my protected health information to be used or disclosed as permitted under Federal law (or State law, to the extent the State law provides greater access rights).

Refuse to sign this Authorization.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, etc.)