

**LOYOLA MARYMOUNT UNIVERSITY STUDENT HEALTH CENTER**  
**One LMU Drive MS-8455 Los Angeles, California 90045-2659**  
**AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION**

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ LMU Student ID # \_\_\_\_\_  
 Former Name (if any) \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Daytime Telephone \_\_\_\_\_ Date last attended LMU \_\_\_\_\_

**INFORMATION TO BE RELEASED FROM:**

I hereby authorize the LMU Student Health Center to release the medical information identified below to the persons or organizations identified below.

**INFORMATION TO BE RELEASED TO:**

Name of Organization/Individual	Address	Fax Number
_____	_____	_____
_____	_____	_____

Purpose or need for this information is: \_\_\_\_\_

**TYPE OF INFORMATION TO BE RELEASED:**

TYPE OF RECORD	DATES OF TREATMENT
<input type="checkbox"/> Immunization Records Only	From _____ To _____
<input type="checkbox"/> Medical Bills for Insurance Reimbursement	From _____ To _____
<input type="checkbox"/> Gynecological Exam and Related Labs	From _____ To _____
<input type="checkbox"/> X-Rays/Copies	From _____ To _____
<input type="checkbox"/> All Medical Records	From _____ To _____
EXCEPT FOR:	
___ Psychiatric/Mental Health Information	
___ Substance Abuse Information	
___ HIV Testing, Treatment & Diagnostic Records	
<input type="checkbox"/> Other Records (specify) _____	From _____ To _____

**PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

_____	_____	_____
Date	Signature of Patient or Legally Responsible Party	Relationship to Patient if Not Patient

**NOTICE: Former students authorizing disclosure of medical records shall provide a copy of their driver's license or other valid identification with signature. The first copy of each item in your medical records is provided at no cost. You will be charged \$10 for each additional copy of the requested medical records. If you feel you will need more copies, be sure to make them from the copy we give you. Upon request, the patient or legally responsible party may receive a copy of this authorization.**

**AUTHORIZATION VALID FOR 90 DAYS ONLY AND MAY BE REVOKED IN WRITING AT ANY TIME PRIOR TO 90 DAYS BY NOTIFYING THE LMU STUDENT HEALTH CENTER**

Office Use only:  
 Date Completed \_\_\_\_\_ By: \_\_\_\_\_ (Patient picked up, faxed, sent)

