

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: _____
 Circle one: Pick up / Fax / Mail

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 _____

(To complete form see reverse side.)

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, mailed)**