**OXNARD COLLEGE STUDENT HEALTH CENTER**

# MEDICAL RECORDS RELEASE AUTHORIZATION

**I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.**

**Patient Name: _____ Birth Date: _____**

**Persons/ Organizations providing medical records: _____**
**Address:_____**
**Phone: _____**
**Fax: _____**

**Persons/Organizations receiving medical records: Oxnard College Student Health Center**
**4000 S. Rose Ave.**
**Oxnard, CA 93033**
**Phone: (805)986-5832**
**Fax: (805)986-5932**

**Healthcare information to be released:**
**_____Medical Records/Chart notes; Dates: _____**
**_____X-Ray, Ultrasound, MRI; Body Part:_____ Date: _____**
**_____Lab work; Date:_____**
**_____Other:_____ Date: _____**

**Purpose of Disclosure:_____**

**I understand that my health care and the payment for my health care will not be affected by signing this form. I understand that if I request, I may see the information described on this form. I understand that I will receive a copy of this authorization.**

**I understand that this authorization will expire on this date: _____**

**I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I do, it will not affect any actions the Oxnard College Student Health Center took prior to receiving the revocation.**

**_____ _____**
**Patient Name or Patient Representative (PRINT) Date**

**_____ _____**
**Patient or Patient Representative (SIGNATURE) Relationship to Patient**