

Emmons Health Center
Occidental College
1600 Campus Rd
Los Angeles, CA 90041
Phone (323) 259-2657—FAX (323) 341-4970



Authorization for Release of Medical or Mental Health Information

By completing this form, you are authorizing the disclosure of individually identifiable health information, as outlined below, consistent with California and Federal law concerning the privacy of such information.

Client Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Expected Graduation Year: _____

I authorize: *(person or facility that has medical and/or mental health information)*

- To release or
 To exchange medical and/or mental health information to/with:

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Types of Disclosure:

Verbal Information Letter/Summary Other: _____

Copies of Records: Please Circle: **Medical Records** **Mental Health/Counseling Records** **Both**

Please note any restrictions: _____

Purpose of Disclosure (Required):

Expiration of Authorization:

Unless otherwise revoked, this Authorization expires on _____.
If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

Signature of Client

Signature of Provider

Date

I request that this authorization be revoked immediately (effective on the following date): _____

Signature of Client: _____
