

**VADEN HEALTH CENTER
AUTHORIZATION TO DISCLOSE MY MEDICAL INFORMATION**

IDENTIFICATION

Patient Name: _____

(Please PRINT full name)

First/Last quarter at Stanford: _____ SU ID: _____

Date of Birth: _____ Telephone Number: _____

DESIGNATION OF MEDICAL INFORMATION MAINTAINED BY VADEN

Please check the applicable medical information from the medical record of Vaden:

Entire Records

Laboratory Test Results

Immunization Records Only

Check this box to include HIV test results

X-Ray Film(s)

Following Portions of the Record Only (please

specify): _____

Note: If you need counseling records, please use the separate CAPS form.

RELEASE TO WHOM

I authorize Vaden Health Center to release the medical information specified above to:

_____.

The purpose of the disclosure is: patient request / other: _____

Please indicate the method of delivery:

Please fax the information to: _____ at (_____)_____.

Please mail the information to (provide name of person or organization and mailing address): _____

OTHER TERMS OF THE AUTHORIZATION

This authorization shall remain in effect from the date I sign until _____
(specify a date or event upon which it will expire, but no longer than six months).

I understand that: (a) the authorization is subject to revocation at anytime, **by written notification only to Vaden** (at the address below), except to the extent that Vaden already disclosed the information; (b) the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected; (c) I may refuse to sign this authorization, (d) Vaden may not condition my treatment upon it being signed; (e) I am entitled to a copy of this authorization.

I agree to pay the fees associated with copying, faxing, and mailing in accordance with my authorization above. **There will be no fee if mailed or faxed directly to a health care provider.**

If fees apply, payment must be received before records are released. You may pay in person, at Vaden Health Center or mail a check or money order to:

**Attention: Medical Records
Vaden Health Center
Stanford University
866 Campus Drive
Stanford, CA 94305-8580**

APPLICABLE FEE

The fee for this service is as follows:

- | | |
|--|------------------------|
| <input type="checkbox"/> Entire Chart (\$20) | Total Due: _____ |
| <input type="checkbox"/> Immunization Record (\$10) | Total Due: _____ |
| <input type="checkbox"/> Small Specific Portion (\$10) | Total Completed: _____ |

SIGNATURE

Signature of Patient or Representative

Date

If signed by patient representative provide a description of authority to act for the patient:
