

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

**NOTICE**

University of the Pacific and many other organizations and individuals are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

**YOUR RIGHTS**

This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing or refusing to sign this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan of which the patient is not already a member, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party. This Authorization may be revoked at any time. The revocation must be in writing, signed by the individual on his/her behalf, and delivered to the Privacy Officer, (209)946-2124, 3601 Pacific Ave, Stockton, CA 95211. The revocation will take effect when Pacific receives it, unless Pacific or others have already relied on it. Immediately upon receipt of a revocation from a student, the Privacy Officer will notify Cowell Wellness Center. Pacific must give you a copy of this Authorization. This information is for use only by the recipient named below. It can not be given to any other individual or agency without the patient's authorization. **Information:** The patient must complete this form in its entirety in order for Cowell Wellness Center to release any medical information. The patient and/or requesting party must be specific as to the nature of the information he/she would like and the purpose for which this is requested. The patient is entitled to receive a copy of this release.

I authorize: University of the Pacific, Cowell Wellness Center, 1041 Brookside Road, Stockton CA 95211  
(Name of Individual or Agency & Complete Address)

209-946-2315 and 209-946-3001  
(Phone) (Fax)

To release to: \_\_\_\_\_  
(Name of Individual or Agency & Complete Address)

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ and \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Phone) (Fax)

- (1) Records of my treatment for dates beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ and ending on \_\_\_\_/\_\_\_\_/\_\_\_\_
- (2) Lab Reports dated: \_\_\_\_\_
- (3) X-ray Reports/Films dated: \_\_\_\_\_
- (4) Immunization Records: \_\_\_\_\_
- (5) Other: \_\_\_\_\_
- (6) For the purpose of: \_\_\_\_\_

This information can not be given to any other individual or agency without the patient's authorization. **This Authorization expires** \_\_\_\_/\_\_\_\_/\_\_\_\_. If no date or event is specified, this Authorization expires one year from the Date specified below.

PRINTED NAME: \_\_\_\_\_ PATIENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ PACIFIC ID#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

MAILED FAX GIVEN  
(circle one)