# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**Sender:** Name of individual/organization: _____ Phone:_____
Mailing Address: _____ Fax:_____

**I authorize the above-named facility to release the following health information as described below** (check the appropriate spaces and include other information where indicated):

**Recipient:** La Sierra University Student Wellness Services, 4500 Riverwalk Parkway, Riverside, CA 92515-8247 Phone: (951) 785-2200 Fax: (951) 785-2263 Email: wellness@ lasierra.edu*

**Purpose of use/disclosure:** This information will be used for the following purpose(s):

Patient's request My personal records Continued care Other (please describe): _____

## Authorization Statements/Signatures:

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient