AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Sender: La Sierra University Student Wellness Services, 4500 Riverwalk Parkway, Riverside, CA 92515-8247

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

Recipient: The information identified may be disclosed to the following individual(s)/organization(s):

Name of individual/organization: ____ Fax: ______________________

Mailing Address: ____ Phone: ______________________

Email*: ______________________________ *please be advised that electronic transmission of information is **NOT** guaranteed to be secure. It is not advised to request that **SENSITIVE** records be transmitted in this way.

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