CALIFORNIA STATE UNIVERSITY, FULLERTON

Environmental Health & Safety

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I, ____, hereby authorize
(Full Name of Employee/Patient) (*Please Print*)

____, to release to
(Individual/Organization Holding Medical Records)

____
(Individual/Organization Authorized to Receive Medical Information)

the following medical information from my personal medical records (describe generally the information desired to be released):

____
____
____
____
____
____

I give my permission for this medical information to be used for the following purpose:

____
____
____
____

but I do not give permission for any other use or re-disclosure of this information.

____
(Full Name of Employee or Legal Representative) (Please Print)

____
(Signature of Employee or Legal Representative)

____
(Date of Signature)

EH&S 6/86, revised 5/2000, 2/2012