CALIFORNIA NORTHSTATE UNIVERSITY
COLLEGE of MEDICINE

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

9700 West Taron Drive
Elk Grove, CA 95757
Immunizations@cnsu.edu

Student Name (Last, First, Middle) _____
Address _____
Phone _____ Student ID _____ Date of Birth _____

**Authorization:** *Student hereby authorizes California Northstate University and its school officials to Release Information to external entities that require Immunization Records in advance of the student's clinical rotations (observerships, clerkships, electives, and sub-internships). The records will be provided solely for the purpose of producing documentation to support the external entities' Immunization Policies.*

**Type of Disclosure:** Verbal Communication & Electronic Copies of Record

**Expiration and Validity of Authorization:** Unless otherwise revoked, this Authorization is effective immediately and shall remain in effect until the student graduates from the College of Medicine.

**Notice:** CNU and many other organizations and individuals such as physicians, hospitals and health plans 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. This Authorization may be revoked at any time by providing written or electronic notice to the Office of Medical Education at OME@cnsu.edu.

A copy of this Authorization shall be valid as an original. You are entitled to receive a copy of this Authorization upon request.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

_____ _____

Signature of the Student Date



Last Revised 7/20/23