



Environmental Health & Instructional Safety
(714) 278-7233 / Fax (714) 278-4533

**CALIFORNIA STATE UNIVERSITY, FULLERTON
ENVIRONMENTAL HEALTH AND INSTRUCTIONAL 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)