CSUF | Environmental Health and Safety
ADMINISTRATION AND FINANCE

Medical Record Information Authorization Release Form

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

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

____
(Individual/Organization Authorized to Receive Medical Information) (Please Print)

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

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

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____

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)

Rev. 8/2022, 9/2025