Form F: Consent for Student health to maintain health information and release of Information to Clinical Rotations

This section to be completed by the student.
Please use ink and print clearly

I, _____born on _____, hereby authorize:
(Student Name)

Touro University-California
Student Health Center
1310 Club Drive
Bldg. H-89 Ste. 1537
Vallejo, CA 94592

By signing below, I consent to have TU-CA Student Health Center maintain copies of my personal health information including:

- **Childhood Immunization records**
- **Physical Examination records**
- **Lab results, including blood serum Antibody titers**
- **Current Immunization records**

I understand I have the right to refuse to sign this form and may revoke the authorization at any time (except to the extent the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. I also am aware that this Authorization will remain in effect for the duration of my time as a student at Touro University California and will expire on the date of my graduation from the University.

Other persons authorized to access my personal health information: (please Initial)

_____ **Clinical Education Coordinators**
_____ **Dean/Associate Dean of College**

Authorization to Release Communicable Disease Clearance Information to Clinical Rotation Sites

By signing below, you consent to release to the extent permitted by law, the following medical information that Touro University California now has in its possession, or that it may create or receive from any third party in the future:

Initial next to the documents you are authorizing for release

_____**Immunization information (including titer results)**

_____ **Drug Screen/Toxicology Reports**

_____**Tuberculosis clearance**

_____**History and Physical Exam report**

Other: _____

The selected above will be released to any of the clinical rotation site(s) of the University that I am or will be assigned to as a student of the University. I understand this information may be provided by email, fax, hand delivery or regular mail. I understand that this information must be provided, if requested, in order to prove to a clinical rotation site that I meet all communicable disease clearance requirements as required by the University. I also understand that if I do not allow this information to be provided by the various clinical rotation sites, a clinical rotation site can refuse to allow me to rotate through its facility. I am also acknowledging that if I cannot complete the clinical rotations required for my degree and/or licensure because of my refusal to authorize the release of my communicable disease clearance information to the clinical rotation sites, I agree to hold the University harmless to the extent permitted by the law.

_____
Signature of Student

By signing this Authorization on this _____day of _____20_____,
I agree with all the provisions stated in this Authorization for the release of the specified information.