Texas State University-San Marcos
Student Health Center, 601 University Dr., San Marcos, TX 78666
Ph. (512) 245-2161 Fax (512) 245-9288

Authorization for Release of Health Information

1. Party Authorized To Release Information (check one only):

___Texas State Student Health Center

___Other Party, Medical Provider or Medical Facility Name_____

Address_____City_____ ST_____Zip_____

Ph. (____)_____Fax (____)_____

2. Information Authorized To Be Released Belongs To:

Patient Name_____TX State ID#_____

Birthdate_____Phone # (____)_____ Address_____

City, ST., Zip_____

3. Please Specify How You Will Use This Information:

_____

4. Please Specify The Information You Want Released:

_____

I understand the information I am authorizing to be released **may not include information about me related to the following unless I give specific authorization by initialing:

_____Psychiatry Resident mental health information _____Medical Provider mental health information

_____Alcohol/drug abuse _____HIV/AIDS _____Sexually transmitted infections and communicable diseases

5. Information May Be Released To:

Name of Party Authorized to Receive Information_____

Address_____City_____ST._____

Zip_____Phone # (____)_____Fax # (____)_____

6. Please specify how your information should be released (circle):

pickup at SHC fax mail written verbally personal inspection encrypted e-mail

7. Statements of Understanding

This authorization may be revoked in writing at any time by contacting the Health Information Management Department, except in the case where information has already been released in good faith.

This authorization will expire ninety (90) days from the signature date or _____(not to exceed 180 days)

My signing this authorization is voluntary and refusing to sign does not condition my treatment at the SHC.

I understand there is a fee I must pay allowed under the Texas State Board of Medical Examiners' rules prior to release of my records. The cost is $.50 per page plus $5.00 to mail or fax. You may call in your credit/debit card # to (512) 245-2026. We routinely do not fax health information. When we do, we normally fax to medical providers or health care facilities only and usually when the mail-delivered photocopies would not reach the recipient in a timely manner. Please allow a 15-day turnaround time for copies.

Please see back side.

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There is a possibility that the information disclosed by this authorization may be redisclosed by the recipient and no longer be protected under federal or state privacy laws.

I understand the facility, its employees, administrators, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Signature_____Date_____

Guardian/Personal Representative Signature_____Date_____

Please explain your authority to act for the patient_____

FOR OFFICE USE ONLY

Verification of Requestor (check)**:**

☐Picture ID ☐Verbal confirmation of information on file ☐Comparison of signature on file

Approval by Medical Provider (check and sign if requested by HIM staff)**:**

☐Approve ☐Deny (Must provide letter describing reason for denial.)

Signature_____

Information Released:

Progress notes_____ Women's clinic form(s)_____

Lab_____Immunizations_____ Medical History_____

Health Summary_____Other_____

Released by: _____ Date_____ #Pg(s)_____

How was information released (circle)**?:**

pick up at SHC(check ID) mail fax written/letter verbally personal inspection encrypted e-mail

For fax: Recipient's fax # confirmed by_____

For encrypted e-mail: Recipient's e-mail address confirmed by_____

Charges: Copy fee $_____Ticket #_____Paid (cashier's initials)_____