

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:

Psychotherapy Notes (requires a separate authorization) 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

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.

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.

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

For fax: Recipient's fax # confirmed by _____

Charges: Copy fee \$ _____ Ticket # _____ Paid (cashier's initials) _____