**Authorization for Release of Health Information**

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

\_\_\_\_\_ Texas State Student Health Center

\_\_**X**\_\_ Other Party, Medical Provider or Medical Facility Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_

 Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Information Authorized To Be Released Belongs To:**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TX State ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address, City, ST, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Purpose For Requesting Information (circle one):** Legal Insurance Personal Continuation of Care Transfer Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Please Specify The Information You Want Released:**\_\_**ADD/ADHD documentation of diagnosis, prescribed medication, psychological testing**\_\_

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 \_\_\_\_\_Mental Health Information \_\_\_\_\_Alcohol/Drug abuse \_\_\_\_\_HIV/Aids \_\_\_\_\_STD’s

**5. Information May Be Released To:** \_\_Texas State University; Student Health Center – Health Information Management\_\_

Address\_\_601 University Dr\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_San Marcos\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_TX\_\_\_Zip\_78666\_\_\_\_\_

Phone (\_512\_)\_\_245-2161\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax (\_512\_)\_\_245-9288\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Specify How Your Information Should Be Released (circle one):**

Pickup at SHC Fax Mailed 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 signature date, or \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (not to exceed 180 days).
* 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 $.10 per page (UPPS 01.04.31) after the first 10 free pages, plus $5.00 fee to mail or fax. You may pay in person at SHC or online. Please allow a 15 day turnaround time for copies.
* My signing of this authorization is voluntary and refusing to sign does not condition my treatment at the SHC.
* There is the 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.

8**. Patient Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Guardian/Personal Representative Signature (for minors only)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please explain your authority to act for the patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR OFFICE USE ONLY**:

Picture ID Verified\_\_\_\_\_\_\_\_\_\_\_ Addition Info\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Revoking Authorization**:

I understand, by signing below, I revoke this Authorization, except in the case where information has already been released in good faith.

**Patient Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 04/2022