TEXAS SOUTHERN UNIVERSITY – STUDENT HEALTH SERVICES

RELEASE OF MEDICAL INFORMATION FORM

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION: *Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.*

Information regarding patient for whom authorization is made:

Full Name: _____

T-Number: _____

Other Name(s) Used: _____

Date of Birth: _____

Address:_____ City:_____ State:_____

Zip Code:_____

Phone: (_____)_____ Email:

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address:_____City:_____ State:_____

Zip Code:_____

Phone: (_____)_____ Fax:_____)_____

Information regarding person or entity who can receive and use this information:

Name: _____

Address:_____City:_____ State:_____

Zip Code:_____

Phone: (_____)_____

Fax: (_____)_____

Circle how the recipient is to receive your health information: **mail** **hold for pick up** **fax**

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Specific information to be disclosed:

□ Medical Record from (insert date) _____ to (insert date) _____

□ Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other (Specify):

_____

Include: (*Indicate by Initialing*)

_____ Drug, Alcohol or Substance Abuse Records

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

The individual signing this form agrees and acknowledges:

(1) **Effective Time Period:** This authorization expires 30 days after it is signed.

(2) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(3) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that information disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____

Date: _____

If Legal Representative, relationship to Patient: _____

Witness _____

Date: _____

For Office Use Only:

_____ Verify requestor's identification

_____ Copy of this request/release/disclosure form entered into student's record

Approval to release medical records: _____ Date: _____