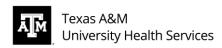


AUTHORIZATION FOR STUDENT HEALTH RECORDS RELEASE

I, the undersigned student, hereby consent to the disclosure of my health information, including without limitation, my "education records" and "treatment records" (as such terms are defined in the Family Educational Rights and Privacy Act) as described in this authorization. I understand that this authorization is voluntary, and I may refuse to sign it.

Patient Name: (print) _						
	Last Name		ne	M.I.	Maiden (i	f applicable)
UIN or Social Security #	#	Date of Bi				
Patient Address:				Day Year	□ F6	emale
City:		State:		Z	ip:	
Phone: ()	E	mail:				
Former Students: Please	provide your dates of atte		To Year Mon			
RELEASE RECORDS T	hese requests are episodic	in nature. Please	submit a sepai	rate form for ea	ach encounter/reques	t.
				Name/Provider/Organization		
Erom	as A&M University - Univers	sity Health	□ From	 Address		
☐ To Attn	: Student Health Records R	elease	□ То			
	4 TAMU ege Station, Texas 77843-1	264		City	State	e ZIP
				Phone	Fax	
Method of Delivery:	Pick-up 🗆 💢 Mail 🗆	Fax 🗆 V	erbal Comm	unication \square	Electronic Fo	ormat 🗆
_	uthorize for release may es, pregnancy, and HIV/A CABLE REQUEST(S):	IDS unless other	rwise marked	d to exclude.	alth, drug or alcoho	ol use/abuse,
□ Copy of Illne	ss/Accident	Da	ate of Service	e(s)/Provider		
□ Copy of X-ra					<u>-</u>	
□ Copy of Pres						
	ng Records/Receipts					
	University Health Service	ces Records (to	include all re	cords from out	tside providers)	
	nunization Records (to i				•	s from outside providers
□ Copy of Oth	er Specified Record(s)					
□ I give permis	ssion for University Heal					e individual listed
Accident	/lllness/lmmunization: _					



		UNIVERSITY HEAL USE ON Processed by:	
Signature of Parent/Legal Guardian	Date		
Printed Name of Parent/Legal Guardian	Relationship		
I agree to the uses and disclosure of my minor child's	s health information as described	l in this authorizat	cion.
I affirm that I have read this authorization and under	rstand its contents; and		
Texas law requires healthcare providers to obtain the consent of and/or billing records to a third party. By signing below:	a minor's parent or legal guardiar	n to disclose a mir	nor's medical
Student/Patient Signature For Parents or Legal Guardians of Minor Patients (under 18 ye	Date ears of age):		
Signature Authorization : I have read this authorization and agred described herein. I understand that refusal to sign this authorizat required or permitted by law, as more fully described in Universit information disclosed pursuant to this authorization may be subjected by federal or state privacy laws.	ion will not prevent the disclosure y Health Services' Notice of Privac	e of my health info cy Practices. I und	ormation as erstand that
Revocation : This authorization will remain valid until revoked. I ugiving written notice to the director of University Health Services. authorization by University Health Services and/or the recipients of the control of the recipients of the control of the co	l further understand that prior ac of my health information will not	ctions taken in reli be affected.	ance on this
PURPOSE FOR THE REQUEST:			
☐ Sexually Transmitted Infection – testing / treatment	□ Other:		
☐ HIV/AIDS testing and or results	☐ Eating Disorder or Nutrition (Counseling	