UNIVERSITY HEALTH SERVICES
TEXAS A&M HEALTH

TEXAS A&M UNIVERSITY

AUTHORIZATION FOR STUDENT HEALTH RECORDS RELEASE

I, the undersigned student, or former student, hereby consent to the disclosure of my health/mental 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 and/or revoke at any time.

Student Name: (print) _____ _____
Last Name First Name M.I. Maiden (if applicable)

TAMU UIN _____ - _____ - _____ Date of Birth: _____/_____/_____
Month Day Year

Student Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email: _____

Former Students: Please provide your dates of attendance: _____ /_____ To _____ /_____
Month Year Month Year

RELEASE RECORDS *Please submit a separate form for each request. If not otherwise noted, this release is valid to release one set of records or for UHS to have one discussion with the person, provider, or organization designated.*

☐ **From**
☐ **To**

UHS – Counseling and Mental Health Care
Attn: Student Counseling Records Release
471 Houston Street / 1263 TAMU
College Station, Texas 77843-1263
(979) 845-4427 Fax (979) 862-4383
UHSinfo@tamu.edu

☐ **From**
☐ **To**

UHS – Medical Primary and Specialty Care
Attn: Student Health Records Release
311 Houston Street / 1264 TAMU
College Station, Texas 77843-1264
(979) 458-8310 Fax (979) 458-8319
UHSpatientservices@tamu.edu

☐ **From**
☐ **To**

_____
Name/Provider/Organization

_____
Address

_____
City State ZIP

_____
Phone Fax

Method of delivery: Pick-up ☐ Mail ☐ Fax ☐ Verbal Communication ☐ Electronic Format ☐

The information you authorize for release may include information regarding mental health, drug or alcohol use/abuse, communicable diseases, pregnancy, and HIV/AIDS unless otherwise marked to exclude.

PLEASE CHECK APPLICABLE REQUEST(S):

Mental Health Services

*** Note Specific Date(s) of Service or Provider below**

- ☐ Copy of ALL Counseling Records
- ☐ Copy of Specific Counseling Records _____
- ☐ Summary of Services
- ☐ I give permission for University Health Services to discuss my mental health treatment with the individual listed above. This authorization is valid for ongoing communication and is valid for six months from today's date, unless I terminate/revoke this authorization with University Health Services Counseling and Mental Health Care.

***PURPOSE FOR THE REQUEST**: _____

**** If you choose to exclude specific information from this request you may list those items below:***

_____

Medical Services

*** Note Specific Date(s) of Service or Provider below**

- ☐ Copy of ALL Health Records (to include all records from outside providers)
- ☐ Copy of a specific Illness/Accident _____
- ☐ Copy of X-ray/Lab _____

- ☐ Copy of Medication List _____
- ☐ Copy of Billing Records/Receipts _____
- ☐ Copy of Immunization Records (to include items administered by UHS and records from outside providers)
- ☐ Copy of Other Specified Record(s) _____
- ☐ I give permission for University Health Services to discuss my ongoing medical treatment with the individual listed above for the following:
  - Accident:_____
  - Illness:_____

  This authorization is valid for ongoing communication and is valid for six months from today's date, unless I terminate/revoke this authorization with University Health Services Primary and Specialty Medical Care.

***PURPOSE FOR THE REQUEST**: _____

**** If you choose to exclude specific information from this request you may list those items below:***

_____

_____

Revocation: This authorization will remain valid until the termination date or immediately revoked. I understand that I can revoke this authorization at any time by giving written notice to the **Senior Director of Mental Health Services** or **Senior Director of Medical Services or their designee.** I further understand that prior actions taken in reliance on this authorization by UHS and/or the recipients of my health information will not be affected.

Signature Authorization: I have read this authorization and agree to the uses and disclosures of my health information as described herein. I understand that refusal to sign this authorization will not prevent the disclosure of my health information as required or permitted by law, as more fully described in UHS's Notice of Privacy Practices. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and may no longer be protected by federal or state privacy laws.

_____

_____ _____

Student/Patient Signature **Date**

For Parents or Legal Guardians of Minor Patients (under 18 years of age):

Texas law requires healthcare providers to obtain the consent of a minor's parent or legal guardian to disclose a minor's medical and/or billing records to a third party. By signing below:

- I affirm that I have read this authorization and understand its contents; and
- I agree to the uses and disclosure of my minor child's health information as described in this authorization.

_____ _____

Printed Name of Parent/Legal Guardian Relationship

_____ _____

Signature of Parent/Legal Guardian Date