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 First Name M.I. Maiden (if applicable)

UIN or Social Security # _____ - _____ - _____ Date of Birth: _____/_____/_____ Check one: □ Male
Month Day Year □ Female

Patient Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email: _____

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

RELEASE RECORDS These requests are episodic in nature. Please submit a separate form for each encounter/request.

□ **From**
□ **To**

Texas A&M University - University Health Services
Attn: Student Health Records Release
1264 TAMU
College Station, Texas 77843-1264

□ **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):

Date of Service(s)/Provider

□ Copy of Illness/Accident _____

□ Copy of X-ray/Lab _____

□ Copy of Prescription _____

□ Copy of Billing Records/Receipts _____

□ Copy of **ALL** University Health Services Records

□ Copy of Immunization Records

□ 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/Immunization: _____

NOTE: <u>Records to exclude from this request</u> – please check the appropriate areas not to be included in your request

- ☐ Mental Health Records – including depression
- ☐ HIV/AIDS testing and or results
- ☐ Sexually Transmitted Infection – testing / treatment
- ☐ Drug or Alcohol use / abuse
- ☐ Eating Disorder or Nutrition Counseling
- ☐ Other: _____

PURPOSE FOR THE REQUEST: _____

Revocation: This authorization will remain valid until revoked. I understand that I can revoke this authorization at any time by giving written notice to the director of University Health Services. I further understand that prior actions taken in reliance on this authorization by University Health Services 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 University Health Services' 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**

UNIVERSITY HEALTH SERVICES USE ONLY

Processed by: _____ Date: _____