AUTHORIZATION to Use or Disclose Protected Health Information

Student Health Services at Texas Woman's University

I authorize the following protected health information (PHI) to be released from the medical record of:

Name (Please Print) _____ Student ID #: _____

Last Name First Name M.I. Maiden (if applicable)

Phone #: _(_____)_____ E-Mail_____ Date of Birth _____ / _____ /_____

Month Day Year

Address _____ City/ST _____ Zip _____

Release Records
☐From
☐To

Texas Woman's University
Student Health Services
P.O. Box 425467
Denton, TX 76204-5467
Fax 940-898-3844
Phone 940-898-3826

Release Records
☐To
☐From

_____
NAME/ORGANIZATION
_____
ADDRESS
_____
CITY STATE ZIP CODE
_____
PHONE ***FAX***

Please release the following information (be specific):

☐ **Records from dates of Service(s)** _____
☐ **Specific Illness(es)** _____
_____

☐ **All Medical Records (including mental / psychological health)**
☐ **Immunization Records**
☐ **Mental / Psychological Health**
☐ **Drug / alcohol / substance abuse**
☐ **HIV / AIDS**

- Please state the purpose for this release: _____

METHOD OF RELEASE (Check One): ____ E-Mail ____ Pick-up ____Fa x ____Mail ____ Verbal/Phone

I understand that, by federal law, Texas Woman's University Student Health Services may not use or disclose my health information, except as provided in the Student Health Services Notice of Privacy Practices, without my authorization. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the PHI described above. I hereby release Texas Woman's University and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing and address it to the person or institution named above that I am authorizing to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

I understand that I may refuse to sign this Authorization. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

I understand that I may be charged a fee of up to $1.00 per page for the first 20 pages and .50 for each additional page. This fee is waived for immunization records and copies provided to a health care provider for continuing medical care. This fee is within the limits allowable by Texas State Law. This request will be granted within 30 days. Any records greater than 10 pages will automatically be mailed.

This authorization will expire in one year unless otherwise specified: _____ (Date).

I have read and understand the information in this authorization form:

Signature of Patient or Legal Representative: _____

Printed Name: _____ *Date:*_____

Office Use Only
Date Completed: _____ Cost: $_____

Provider approval for release? Yes No Initial: _____

Privacy Information Statement: *"State law requires that you be informed of the following: (1) you are entitled to request to be informed about the information about yourself collected by use of this form (with a few exceptions as provided by law); (2) you are entitled to receive and review that information; and (3) you are entitled to have the information corrected at no charge to you."* *REVISED 02/2016*
Approved by GC June 2003