Texas A&M-University Commerce· Student Health Services
PO BOX 3011 Commerce, Texas 75428
903-886-5853/903-886-5854 Fax

Authorization to Release Health Information

Patient Name: _____ DOB: _____
Last **First** **M.I.**

I Authorize:_____ To Release to: _____

Address:_____ Address:_____

_____ _____

Phone Number _____ Phone_____

Fax Number: _____

This information is needed for the purpose of:

☐ at the request of individual ☐ Medical Care ☐ Other_____

Date information is needed by:_____

Information is to be sent via: patient pick-up send by mail fax to:_____

Treatments Dates To Be Included: _____ **to** _____

Please check all applicable information requested:

☐ History and Physical ☐ MD Progress Notes ☐ Laboratory Reports ☐Medication Records
☐ Diagnostic Imaging Reports ☐ Others(please specify)_____

I understand that the information to be released may include information regarding a medical condition that is protected by Federal Law. Unless otherwise indicated, this information will not be released to the organization, agency or individual named on this request.

I (patient name)_____authorize release of the following information:

☐ Drug Abuse/Dependence ☐HIV Test Results ☐Psychiatric Conditions
☐Alcohol Abuse/Dependence ☐HIV/AIDS/ARC Infection

I request and authorize the above named health care provider to release the information specified to the organization, agency, or individual named on this request. This authorization is subject to revocation at any time except to the extent that action has been taken and expires **180 days** for the date signed. The facility to which this authorization is directed, its employees and authorized representatives are hereby released from legal responsibility or liability for the provision of information as authorized above. I understand that this information that is being released is subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

If patient is unable to sign or is a minor, complete the following:

Minor of _____ age. Unable sign because:_____