Student Health Center
& Campus Pharmacy
Division of Student Affairs

Authorization for Release of Medical Records

Health 2, 4349 Martin Luther King Blvd., Room 2005 Houston, Texas 77204-3019
Phone: 713-743-5151 • FAX: 713-743-5164

_____ _____ ( ) -
Name of Patient (Please Print) **Date of Birth** **Phone Number**

_____
Email Address

INFORMATION TO BE RELEASED: The signature of a minor patient is required for the release of some of these items.

☐ **All health information**	☐ History & Physical	☐ Physician's Orders	☐ Immunizations
☐ Progress Notes	☐ Pathology Reports	☐ History/Physical Exam	☐ Patient Allergies
☐ Discharge Summary	☐ Billing Information	☐ Medications	☐ Operation Reports
☐ Diagnostic Test Reports	☐ Radiology Reports & Images	☐ Lab Results	☐ Consultation Reports
☐ Other _____			

Your initials are required to release the following information

_____Mental Health Records (excluding psychotherapy notes) _____Genetic Information (including Genetic Test Results)
_____Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

I authorize __UH Student Health Center__ to disclose Protected Health Information to:

To: _____
Print Person/Organization Name Self, etc.
Address/phone/fax:

_____

I authorize _____ to disclose Protected Health Information to:

To: UH Student Health Center

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PATIENT INFORMATION IS NEEDED FOR:

☐ Treatment/Continuing Medical Care	☐ Insurance	☐ Social Security/Disability	☐ School	☐ Military
☐ Insurance	☐ Personal Use	☐ Legal Purposes	☐ Billing/Claims	☐ Employment
☐ Other:_____				

EFFECTIVE TIME PERIOD. Unless I revoke this authorization on an earlier date, this authorization shall terminate on _____, or within six months from today's date, whichever occurs sooner.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving *written* notice stating my intent to revoke this authorization to the person or organization named in this authorization. I understand that my failure to sign this form or revoke this authorization cannot stop the disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1).

AUTHORIZATION:

- I have read this form and agree to the uses and disclosures of the information as described.
- I understand I understand that treatment or payment *cannot* be conditioned on my signing this authorization and that I may be charged a retrieval/processing fee for copies of my medical records.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.
- I hereby release the University of Houston System, each of its university components and departments, and any of their employees, officers, health care providers, and agents from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE X_____ _____

Physical Signature of Individual or Individual's Legally Authorized Representative **Date**
(*Electronic or Digital Signatures will not be accepted*)

Printed Name of Legally Authorized Representative (if applicable):

_____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____

Physical Signature of Minor Individual – if applicable **Date**
(*Electronic or Digital Signatures will not be accepted*)

FOR OFFICE USE ONLY

If submitted in person or by mail/fax: _____ _____

Date Request Received: Identification Presented: