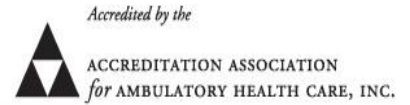




Sam Houston State University Health Center
 1608 Avenue J
 Huntsville, Texas 77341
 Ph: 936-294-1805
 Fax: 936-294-1804



Authorization for Release of Health Information

PATIENT INFORMATION			
Patient Name _____		Student ID# _____	
Birthdate _____	Phone # (_____) _____	Address _____	
City _____		ST _____	Zip _____

OR																									
<input type="checkbox"/> RELEASE INFORMATION TO: I authorize the SHSU Health Center to release my health information to the following individual/healthcare provider: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td colspan="2">Name</td></tr> <tr><td>Fax</td><td>Phone</td></tr> <tr><td colspan="2">Address</td></tr> <tr><td colspan="2">City</td></tr> <tr><td>State</td><td>Zip</td></tr> <tr><td colspan="2">Method of Disclosure: <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Verbal <input type="checkbox"/> Email <input type="checkbox"/> Pick-up (Date) _____</td></tr> </table>	Name		Fax	Phone	Address		City		State	Zip	Method of Disclosure: <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Verbal <input type="checkbox"/> Email <input type="checkbox"/> Pick-up (Date) _____		<input type="checkbox"/> OBTAIN INFORMATION FROM: I authorize the healthcare entity listed below to release my information to the SHSU Health Center. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td colspan="2">Name</td></tr> <tr><td>Fax</td><td>Phone</td></tr> <tr><td colspan="2">Address</td></tr> <tr><td colspan="2">City</td></tr> <tr><td>State</td><td>Zip</td></tr> <tr><td colspan="2">SHSU Health Center to receive information: <input type="checkbox"/> Tom Hill, MD <input type="checkbox"/> Greschen Yount, MD <input type="checkbox"/> Pamela Stanosheck, FNP-C</td></tr> </table>	Name		Fax	Phone	Address		City		State	Zip	SHSU Health Center to receive information: <input type="checkbox"/> Tom Hill, MD <input type="checkbox"/> Greschen Yount, MD <input type="checkbox"/> Pamela Stanosheck, FNP-C	
Name																									
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SHSU Health Center to receive information: <input type="checkbox"/> Tom Hill, MD <input type="checkbox"/> Greschen Yount, MD <input type="checkbox"/> Pamela Stanosheck, FNP-C																									

Comments/Notes

<p>Unless otherwise restricted below, this consent allows for the release of your entire medical record.</p> <input type="checkbox"/> Exclude information about: <input type="radio"/> Mental Health Information, <input type="radio"/> Alcohol/Drug Use, <input type="radio"/> HIV/AIDS, <input type="radio"/> Sexually Transmitted Infections <input type="checkbox"/> Limited to treatment records from (insert date) _____ to (insert date) _____ <input type="checkbox"/> Limited to the treatment of the following medical conditions _____ _____

<p>STATEMENTS OF UNDERSTANDING</p> <ul style="list-style-type: none"> This authorization may be revoked in writing at any time by contacting the Student Health Center, except in the case where information has already been released in good faith. There is a possibility that the information disclosed by this authorization may be released by the recipient and no longer be protected under federal or state privacy laws. I understand the facility, its employees, administrators, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

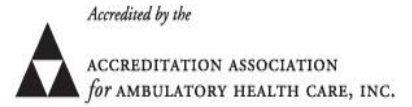
Patient Signature _____ Date _____

Guardian/Personal Representative Signature _____ Date _____

Please explain your authority to act for the patient _____



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SHC OFFICE USE ONLY

Verification of Requestor (check):

- Picture ID Verbal confirmation of information on file Comparison of signature on file

Signature_____

How was information released (circle)?:

pick up at SHC(check ID) mail fax written/letter verbally personal inspection

For mail: Recipient's address confirmed by_____

For fax: Recipient's fax # confirmed by_____