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

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Authorization for Release of Health Information

PATIENT INFORMATION

Patient Name_____ Student ID#_____

Birthdate_____Phone # (_____)_____ Address_____

City_____ST_____Zip_____

OR

☐ RELEASE INFORMATION TO:

I authorize the SHSU Health Center to release my health information to the following individual/healthcare provider:

Name	
Fax	**Phone**
Address	
City	
State	**Zip**

Method of Disclosure:
☐ **Fax** ☐ **Mail** ☐ **Verbal** ☐ **Email**
☐ **Pick-up (Date)**_____

☐ OBTAIN INFORMATION FROM:

I authorize the healthcare entity listed below to release my information to the SHSU Health Center.

Name	
Fax	**Phone**
Address	
City	
State	**Zip**

SHSU Health Center to receive information:
☐ **Robert Williams, MD**
☐ **Tom Hill, MD**
☐ **Greschen Yount, MD**
☐ **Pam Stanosheck, FNP-C**
☐ **Janet Mehalick, FNP-C**

Comments/Notes

Unless otherwise restricted below, this consent allows for the release of your entire medical record.

☐ Exclude information about: ❍Mental Health Information, ❍Alcohol/Drug Use, ❍HIV/AIDS, ❍Sexually Transmitted Infections
☐ Limited to treatment records from (insert date) _____ to (insert date)_____
☐ Limited to the treatment of the following medical conditions_____
_____

STATEMENTS OF UNDERSTANDING

- 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_____

SHC STAFF COMPLETE BACK OF FORM

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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_____

SHC STAFF COMPLETE BACK OF FORM