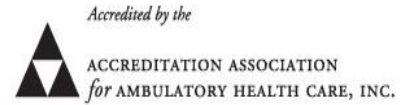




Sam Houston State University Health Center  
 1608 Avenue J  
 Huntsville, Texas 77341  
 Ph: 936-294-1805  
 Fax: 936-294-1804



## Authorization for Release of Health Information

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

<b>OR</b>	
<input type="checkbox"/> <b>RELEASE INFORMATION TO:</b>	<input type="checkbox"/> <b>OBTAIN INFORMATION FROM:</b>
I authorize the SHSU Health Center to release my health information to the following individual/healthcare provider:	I authorize the healthcare entity listed below to release my information to the SHSU Health Center.
<b>Name</b>	<b>Name</b>
<b>Fax</b> <b>Phone</b>	<b>Fax</b> <b>Phone</b>
<b>Address</b>	<b>Address</b>
<b>City</b>	<b>City</b>
<b>State</b> <b>Zip</b>	<b>State</b> <b>Zip</b>
<b>Method of Disclosure:</b> <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Verbal <input type="checkbox"/> Email <input type="checkbox"/> Pick-up (Date) _____	<b>SHSU Health Center to receive information:</b> <input type="checkbox"/> Robert Williams, MD <input type="checkbox"/> Pam Stanosheck, FNP-C <input type="checkbox"/> Tom Hill, MD <input type="checkbox"/> Janet Mehalick, FNP-C <input type="checkbox"/> Greschen Yount, MD

<b>Comments/Notes</b>
-----------------------

<p><b>Unless otherwise restricted below, this consent allows for the release of your entire medical record.</b></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><b>STATEMENTS OF UNDERSTANDING</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> </ul>
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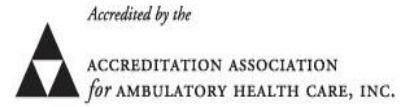
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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\_\_\_\_\_