Sam Houston State University

MEMBER THE TEXAS STATE UNIVERSITY SYSTEM

Student Health Center

Phone: 936-294-1805 Fax: 936-294-1804

Authorization to Release or Disclose Patient Information

Patient Name_____ SHSU ID# _____Date of Birth___/___/____

Address _____ City _____

State _____Zip Code_____ Phone # (_____) _____

RELEASE INFORMATION: I authorize the release of my health information between the facilities listed below:

T O	**Facility Name:** _____ **Address:** _____ _____ **Phone:** _____ **Fax:** _____	**F R O M**	**Facility Name:** _____ **Address:** _____ _____ **Phone:** _____ **Fax:** _____

REQUESTED METHOD OF TRANSMISSION (check one) *Allow up to 5 business days for your request to process*

☐Fax ☐ Postal Mail ☐ Pick up in person ☐ Secure/Encrypted Email _____

RELEASE: Please check next to each item you want released

____Psychotherapy/Mental Health ____Alcohol/Drug Abuse ____HIV/AIDS

____STI/Sexual Health ____ Immunization/ Meningitis Record ____ALL records available

____Other/Specify: _____

PATIENT SIGNATURE BELOW INDICATES UNDERSTANDING OF THE FOLLOWING

- The information disclosed by this authorization could be re-disclosed by the recipient and no longer be protected under federal or state Privacy laws.
- Unless specified otherwise, the information will be released through the method requested by the receiving party (fax, secure email, Postal mail, or pick-up), and the facility releasing the information will exert good faith but cannot guarantee the final destination.
- In the case of email transmission, the health center may only send records through a secure message or the SHC Portal.
- Refusal to sign this authorization in no way affects treatment, payment, enrollment in a health plan, or eligibility for benefits.
- This authorization is valid for **1 year from the date signed** unless revoked in writing by the patient.
- This authorization may be revoked at any time by notifying SHSU Student Health Center in writing, except in the case where information has already been released in good faith. It is understood the revocation will take effect after it is received by the Health Center.

_____/_____/_____/_____

Printed Name of Patient or Guardian **Signature** **Date**