Student Health Services
DIVISION OF STUDENT AFFAIRS

Website: shs.tamu.edu
Patient Services: (979) 458-8310
Fax: (979) 458-8319

AUTHORIZATION FOR STUDENT HEALTH RECORDS RELEASE

Patient Name: (print) _____
Last Name First Name M.I. Maiden (if applicable)

UIN or Social Security # _____ - _____ - _____ Date of Birth: _____/_____/_____ Check one: ☐ Male
Month Day Year ☐ Female

Patient Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email: _____

Former Students: Please provide your dates of attendance: _____ /_____To _____ /_____
Month Year Month Year

RELEASE RECORDS These requests are episodic in nature. Please submit a separate form for each encounter/request.

☐ **From**
☐ **To**

Texas A&M University - Student Health Services
Attn: Student Health Records Release
1264 TAMU
College Station, Texas 77843-1264

☐ **From**
☐ **To**

_____
Name/Provider/Organization

_____
Address

_____
City State ZIP

_____ _____
Phone Fax

Method of Delivery: Pick-up ☐ Mail ☐ Fax ☐ Verbal Communication ☐ Electronic Format ☐

REDISCLOSURE - to Recipient: This information is being disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibits you from making any further disclosure of this information except with specific written consent of the person to who it pertains.

The information you authorize for release may include information regarding mental health, drug or alcohol use/abuse, communicable diseases, pregnancy, and HIV/AIDS unless otherwise marked to exclude.

PLEASE CHECK APPLICABLE REQUEST(S):

Date of Service(s)/Provider

☐ Copy of Illness/Accident _____
☐ Copy of X-ray/Lab _____
☐ Copy of Prescription _____
☐ Copy of Billing Records/Receipts _____
☐ Copy of **ALL** SHS Health Records (to **include** all records from outside providers)
☐ Copy of Immunization Records (to include items administered by SHS and records from outside providers)
☐ Copy of Other Specified Record(s) _____
☐ I give permission for SHS to discuss my ongoing medical treatment with the individual listed above for the following:
Accident/Illness/Immunization: _____

NOTE: Records to exclude from this request – please check the appropriate areas not to be included in your request

☐ Mental Health Records – including depression
☐ HIV/AIDS testing and or results
☐ Sexually Transmitted Infection – testing / treatment
☐ Drug or Alcohol use / abuse
☐ Eating Disorder or Nutrition Counseling
☐ Other: _____

PURPOSE FOR THE REQUEST: _____

_____ _____
Student/Patient Signature or Parent/Guardian if patient is under 18 **Date**

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STUDENT HEALTH RECORDS RELEASE
Rights and Procedures

The following provide you with information on your rights and the procedures for exercising your rights to Student Health Record information about you; and furthermore, it puts you on notice of the uses and disclosures expected to be made of your Student Health Record information.

- I understand that Student Health Services, herein referred to as the SHS, has reserved the right to change its privacy practices.
- I understand that my Student Health Record information may be used to carry out treatment, sent to insurance carriers for payment, or for health care operations.
- I acknowledge that the information used or disclosed to any entity other than a health plan or health care provider may no longer be protected by the federal privacy law.
- I understand that I have the right to request restrictions on how information is used or disclosed to carry out treatment, payment, or health care operations.
- I understand that SHS is not required to agree to any of such restriction(s) but if SHS does agree to my restriction(s), that SHS is bound by the restriction(s).
- I understand that I reserve the right to review the notice prior to signing the consent.
- I understand that I have the right to revoke the consent to release or restrict my Student Health Record, except to the extent that SHS has already acted in reliance on the consent.
- I understand that this consent must be signed by me or by my parent/guardian if I am under 18 years of age and have not been emancipated.
- I understand that there are permitted uses and disclosures for which authorization is not required as in disclosures and uses for public health activities; health oversight activities; judicial and administrative proceedings; coroners and medical examiners; general law enforcement purposes; disclosures of directory information; insurance and payment processes; research purposes; emergency circumstances; or if there are circumstances where such agreement cannot practicably or reasonably be obtained; special classes such as for military purposes, the Department of Veteran Affairs, the Intelligence community, Department of State, and Foreign Services or other United States Government employees for medical clearance determinations; and other uses and disclosures where such use or disclosure is required by law and the use of disclosure meets all relevant requirements of such law.
- I understand that I have the right to request the following with respect to my Student Health Record information: (i) Inspection and copying; (ii) Amendment or correction; and (iii) An accounting of the disclosures of such information by the SHS.
- I understand that I have the right to complain to SHS, or the Department of Education if I believe that my privacy rights have been violated.
- I understand that I may file a complaint with the *Privacy Point of Contact* for SHS or the SHS Director by calling (979) 458-8300 and by completing the SHS online contact form.

Privacy Information Statement

"State law requires that you be informed of the following: (1) you are entitled to request to be informed about the information about yourself collected by use of this form (with a few exceptions as provided by law); (2) you are entitled to receive and review that information; and (3) you are entitled to have the information corrected at no charge to you."

Record released by: _____ _____
Student Health Center Staff *Date*

☐ *Disclosure documented by SHS* _____
Staff Initials