Sam Houston State University

MEMBER THE TEXAS STATE UNIVERSITY SYSTEM

STUDENT HEALTH CENTER

Authorization to Release or Disclose Patient Information

***You are required to submit a separate form for each encounter/request.**

Patient Name(print): _____Sam ID: 000_____

Date of Birth: ___/___/_____ Phone: _____ Email:_____

Address:_____

City:_____ State:_____ Zip:_____

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

I authorize the release of my health information:

☐ From SHSU Student Health Services Phone: 936-294-1805 Fax: 936-294-1804

☐ To 1608 Avenue J, PO Box 2358 Huntsville Texas 77341

Release Information: ☐ From ☐ To _____
Name/Provider/Organization

_____
Address **City** **State** **Zip**

_____
Phone **Fax** **Email**

Please check Records to Release: Dates for Request: **From** _____/_____/_____ **To** _____/_____/_____

☐ Copy of **ALL** Student Health Records (to include all records from outside providers)
☐ Copy of Immunization Records (to include items administered by SHC and records from outside providers)

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

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

Method of Delivery: ☐ In Person Pick-up ☐ Mail ☐ Fax ☐ Secure Electronic Format

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.

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

(8/22 updated)