



# 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)