Texas State University
Student Health Center, 601 University Dr. San Marcos, TX 78666
Phone: 512-245-2161 Fax: 512-245-9288

Authorization for Release of Health Information

1. Party Authorized to Release Information (check one only):

☐ Texas State Student Health Center
☑ Other Party, Medical Provider or Medical Facility

_____
Name

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

( ) _____ ( ) _____
Phone *Fax*

2. Information Authorized to be Released Belings to:

_____ _____ _____
Patient Name *TX State ID Number* *Birthdate*

( ) _____ _____
Phone *Address, City, State, Zip Code*

3. Purpose for Requesting Information (check one):

☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care ☐ Transfer ☐ Other: _____

4. Please Specify the Information You Want Released: _____

I understand the information I am authorizing to be released **may not** include information about me related to the following unless I give specific authorization by **initialing**:

____Psychotherapy Notes ____Mental Health Information ____Alcohol/Drug Abuse
____HIV/Aids ____STD's

5. Information may be released to: Texas State Student Health Center

601 University Drive | San Marcos | Texas | 78666
Address *City* *State* *Zip Code*

(512) 245-2161 | (512) 245-9288
Phone *Fax*

6. Specify How Your Information Should be Released (check one):

☐ Pickup at SHC ☑ Fax ☐ Mailed ☐ Written ☐ Verbally ☐ Personal Inspection ☐ Encrypted Email

_____
Email Address

7. Statements of Understanding:

- This authorization may be revoked in writing at any time by contacting the Health Information Management Department, except in the case where information has already been released in good faith.
- This authorization will expire ninety (90) days from signature date, or _____ (not to exceed 180 days).
- I understand there is a fee I must pay allowed under the Texas State Board of Medical Examiners' rules, prior to release of my records. The cost is $0.10 per page (UPPS 01.04.31) after the first 10 free pages, plus $5.00 fee to mail or fax. You may pay in person at SHC or online. Please allow a 15 day turnaround time for copies.
- My signing of this authorization is voluntary and refusing to sign does not condition my treatment at the SHC.
- There is the possibility that the information disclosed by this authorization may be redisclosed by the recipient and no longer be protected under federal or state privacy laws.
- 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.

8. Patient Signature: _____ _____
Date

_____ _____
Guardian/Personal Representative Signature (for minors only) *Date*

_____
Please explain your authority to act for the patient

For Office Use Only:

_____ _____
Picture ID Verified *Additional Information*

Revoking Authorization:

I understand, by signing below, I revoke this Authorization, except in the case where information has already been released in good faith.

_____ _____
Patient Signature *Date*

Revised: 01/03/2023