# AUTHORIZATION FOR STUDENT HEALTH RECORDS RELEASE

**Student Health Services (SHS) at A. P. Beutel, Texas A&M University, Mail Stop 1264**
**College Station, Texas 77843-1264 Phone (979) 458-8310 Fax (979) 458-8319**

Name (Please Print) ______________________________________________
Last Name First Name M.I. Maiden (if applicable)
UIN or Social Security # _________-______-__________ Date of Birth _________________ / ______ / _______
Please check one: ☐ Male ☐ Female Married: ☐ Yes ☐ No Month Day Year
Student's Address ______________________________________________
City ______________________ State _____________ Zip ______________

Phone # (______) ______________________ Email: ______________________

Please give your dates of attendance _______ /_______To _______ /_______
Month Year Month Year

Method of Delivery: Pick-up ☐ Mail ☐ Fax ☐

**I AUTHORIZE SHS TO OBTAIN MY HEALTH INFORMATION FROM:**
Name/Organization ______________________________________________
Address ______________________________________________
City ______________________ State _____________ Zip ______________
Phone # (______) ______________________ Fax # (______) ______________________

**I AUTHORIZE SHS TO RELEASE MY HEALTH INFORMATION TO:**
Name/Organization ______________________________________________
Address ______________________________________________
City ______________________ State _____________ Zip ______________
Phone # (______) ______________________ Fax # (______) ______________________

Attention: ______________________________________________

**REDISCLOSURE:** **This information is being disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit 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.**

**PLEASE CHECK APPLICABLE REQUESTS:**
- ☐ Copy of Immunization Records (to include items administered by SHS and records from outside providers – not for official use)
- ☐ Copy of illness/Accident: From______________________ To: ______________
- ☐ Copy of X-ray/Lab: From______________________ To: ______________
- ☐ Copy of Prescription: From ______________________ To: ______________
- ☐ Copy of **ALL** SHS Health Records (to **include** all records from outside providers, to **exclude** items in the 'Other' category below)
- ☐ Other (mental health, drug or alcohol use/abuse, HIV/AIDS, nutrition, physical therapy, pregnancy, etc.), Please specify:

______________________________________________

**PURPOSE FOR THE REQUEST:** ______________________________________________

______________________________________________

Student Health Services accepts payments of check, Aggie bucks, Visa, MasterCard, & Discover.
For payment by credit card, please call (979) 458-8310. A cost schedule is available at http://shs.tamu.edu/forms.htm
If we do not have the records you are requesting, you will not be charged.

## PLEASE TURN OVER

# HEALTH RECORDS RELEASE

**Student Health Services at A. P. Beutel, Texas A&M University**

(Continued)

The following provide you with information on your rights and the procedures for exercising your rights to protected health information about you; and further more, it puts you on notice of the uses and disclosures expected to be made of your protected health information.

- I understand that my protected health information may be used to carry out treatment, sent to insurance carriers for payment, or for health care operations.
- I understand that I reserve the right to review the notice prior to signing the consent.
- I understand that Student Health Services at A. P. Beutel, herein referred to as the SHS, has reserved the right to change its privacy practices.
- I understand that I have the right to request the SHS to restrict how information is used or disclosed to carry out treatment, payment, or health care operations.
- I understand that the SHS is not required to agree to any of such restrictions.
- I understand that if the SHS does agree to my restrictions, the SHS is bound by the restriction.
- I understand that the authorization expires after 180 days.
- I understand that I have the right to revoke the consent, except to the extent that the SHS has already acted in reliance on the consent.
- I understand that this consent must be signed by me or by my parent or 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; banking and payment processes; research purposes; emergency circumstances; disclosures to next-of-kin if I verbally agreed to the disclosure; or 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 may request that certain uses and disclosures of my protected health information be restricted, and SHS is not required to agree to such a request.
- I understand that I have the right to request, and a description of the procedures for exercising, the following with respect to my protected health 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 may complain to the Health Information Management Administrator, Student Health Services at A. P. Beutel, telephone: (979) 458-8360 and to the Department of Health & Human Services (DHHS) if I believe that my privacy rights have been violated.
- 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.

______________________________ ______________

Patient Signature Date

______________________________

Student ID #

______________________________ ______________

Parent or Guardian Signature Date

Record released by: ______________________________ Date: ______________________________

## 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."*