AUTHORIZATION TO RELEASE MEDICAL RECORDS

The University of Texas at Dallas Student Health Center, 800 W. Campbell Rd, SSB 43
Richardson, TX 78080-3027 Phone: (972) 883-2747 Fax: (972) 883-2069

Name (Please Print) _____ Phone#: ( ) _____
(Last Name, First Name, M.I. Maiden)

Student ID #_____ Date of Birth _____/_____/_____
Month Day Year

Address_____ City/State _____ Zip Code _____

- By signing this form, I authorize: The University of Texas at Dallas Student Health Center
  Person or Organization that is to release information

800 W. Campbell Road	Richardson, TX 75080	972-883-2747	972-883-2069
Address	**City/State /Zip Code**	**Phone#**	**Fax#**

- To disclose to: _____
  Person or Organization that is to receive information

Address	**City/State/Zip Code**	**Phone#**	**Fax#**

Please release the following information (be specific):

☐ **Records from date of service(s)** _____

☐ **Specific Illness(es)** _____

☐ **All Medical Records** ☐ **Drug/alcohol/substance abuse** ☐ **HIV/AIDS**

Please state the purpose for this release: _____

METHOD OF RELEASE (Check One): ____ Mail ____ Fax _____ Phone (confer with orally) ____ Pick-up

I understand that, by federal law, UT Dallas Student Health Center may not use or disclose my health information, except as provided in the Student Health Center Notice of Privacy Practices, without my authorization. My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the PHI described above. I hereby release UT Dallas and its employees from and all liability that may arise from the release of information as I have directed

I understand that specific privacy laws protect this information, but it is my desire that any such information be released pursuant to this authorization. I understand that once this information is released, these privacy laws may no longer apply.

I also understand that I have the right to revoke this authorization at any time but that such revocation will have no effect on any release made pursuant to its release prior to its revocation.

I have read and understand this authorization, and authorize the use and/or disclosure of the health information as described in this authorization.

Signature of Patient or Legal Representative: _____
Printed Name: _____ Date: _____

Privacy Information Statement: With few exceptions, you are entitled on your request to be informed about the information U.T. Dallas collects about you. Under Sections 552.021 and 522.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have U.T. Dallas correct information about you that is held by us and that is incorrect.