

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: _____
Person or Organization that is to release information

Address	City/State /Zip Code	Phone#	Fax#
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➤ To disclose to: The University of Texas at Dallas Student Health Center
Person or Organization that is to receive information

800 W. Campbell Rd, SSB 4.700, MS SSB 43	Richardson, TX 75080	972-883-2747	972-883-2069
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Address	City/State/Zip Code	Phone#	Fax#
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Please release the following information (be specific):

Records from date of service(s) _____

Specific Illness (es) _____

All Medical Records Medical Records **EXCEPT** Drugs and HIV/AIDS HIV/AIDS Only

Drug /alcohol/substance abuse Birth Control

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: _____

Release expires one year from the date listed on the form

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.