Sam Houston State University
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: _____

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
☐ **To** 1608 Avenue J, PO Box 2358
Huntsville Texas 77341
Phone: 936-294-1805
Fax: 936-294-1804

☐ **From** _____
☐ **To** Name/Provider/Organization
_____
Address
_____
City State Zip
_____
Phone Fax

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)
☐ Other: _____

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**

(11/24 updated)