

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

University of Houston Student Health Center

100 UH Health Center

Houston, Texas 77204-3019

Phone: (713)743-5151 Fax: (713)743-5164

I _____ (Full Name) _____ (Date of Birth)

authorize the following information be released:

- () History & Physical () Psychiatric Assessment () Progress Report () Dr. Notes
() Nurse Notes () Dr. Orders () Consultation Report () Lab Report
() Radiology Report () X-Ray Film/Copies () Other: _____

I request copies of my records to be transferred, (circle and initial which option(s) apply)

_____ To: UH Student Health Center FROM: _____
(Initials) (Print name of organization)

(Name and complete address of organization to which disclosure is to be made)

_____ To: _____ From: UH Student Health Center
(Initials) (Print name of organization)

(Name and complete address of organization to which disclosure is to be made)

- For the purpose of () Continuing Medical Care () Insurance () Legal Purposes () Military
() Social Security/Disability () Personal Use () School () Other (list below)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand I may be charged a retrieval/processing fee and for copies of my medical records. I understand my treatment will not be conditioned by my completion of this form. I understand that I may revoke this authorization in writing at any time except the extent that action has been taken in reliance upon the authorization. If this authorization is not earlier revoked, this authorization shall terminate on _____, or within six months from today's date, whichever occurs sooner.

(Please Print)

Date: _____ Signature: _____

Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative

Relationship to Patient

Rev. 04\28\05

To the third party receiving alcohol or drug abuse patient records: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part II. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.