UNIVERSITY of HOUSTON

STUDENT HEALTH CENTER

Authorization for Release of Medical Records

All information is considered confidential and will not be released without the patient's written consent or a signed court order. The UH Student Health Center retains medical records for 10 years past the last date on which the service was given (22 TAC §§ 165).

Your medical records may include 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).

There is a **charge** for this service.

To request copies of your records

Send or bring a completed **Authorization for Release of Medical Records Form** and payment for applicable **fees**.

IN PERSON

Submit an **Authorization for Release of Medical Records Form** with applicable **fees** and a picture ID to the Student Health Center front desk. Visa or MasterCard accepted.

MAILED REQUESTS

Send a completed **Authorization for Release of Medical Records Form,** legible copy of your driver's license and applicable **fees** to the UH Student Health Center. Checks or money orders accepted.

FAX REQUESTS

Fax a completed **Authorization for Release of Medical Records Form** and a legible copy of your driver's license to the UH Student Health Center. Contact the UH Student Health Center at 713-743-5151 after faxing your request to render payment of applicable **fees** by Visa or MasterCard.

The UH Student Health Center will process an authorized request for medical records within approximately seven to fifteen business days after the recent of a valid request and applicable **fees** . Records may be sent by mail or held for pick-up. Upon request, the UH Student Health Center will fax records up to five pages for an additional **fee**. Records over five pages cannot be faxed.

The UH Student Health Center does not re-release records generated by another health care facility. You should contact the applicable health care facility if you require copies of these records.

Important Notice Regarding Social Security Numbers

UH Student Health Center medical records generated prior to January 2007 could contain your social security number (SSN) and

UNIVERSITY of HOUSTON

STUDENT HEALTH CENTER

Health 2
4849 Calhoun Road, Room 2005
Houston, Texas 77204-3019
713-743-5151 • FAX: 713-743-5164

Authorization for Release of Medical Records

_____ _____ (_____) _____-_____

Name of Patient (Please Print) **Date of Birth** **Phone Number**

INFORMATION TO BE RELEASED: The signature of a minor patient is required for the release of some of these items.

☐ **All health information**	☐ History & Physical	☐ Physician's Orders	☐ Immunizations
☐ Progress Notes	☐ Pathology Reports	☐ History/Physical Exam	☐ Patient Allergies
☐ Discharge Summary	☐ Billing Information	☐ Medications	☐ Operation Reports
☐ Diagnostic Test Reports	☐ Radiology Reports & Images	☐ Lab Results	☐ Consultation Reports
☐ Other _____			

Your initials are required to release the following information

_____Mental Health Records (excluding psychotherapy notes) _____Genetic Information (including Genetic Test Results)
_____Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

I authorize __UH Student Health Center__ to disclose Protected Health Information to:

To: _____
Print Person/Organization Name Self, etc.
Address/phone/fax:
_____

I authorize _____ to disclose Protected Health Information to:

To: _____**UH Student Health Center**_____
Print Person/Organization Name Self, etc.
Address/phone/fax:
Health 2, 4849 Calhoun Road, Room 2005, Houston, Texas, 77204-3019 Phone: 713-743-5151 Fax: 713-743-5164

PATIENT INFORMATION IS NEEDED FOR:

☐ Treatment/Continuing Medical Care	☐ Insurance	☐ Social Security/Disability	☐ School	☐ Military
☐ Insurance	☐ Personal Use	☐ Legal Purposes	☐ Billing/Claims	☐ Employment
☐ Other:_____				

EFFECTIVE TIME PERIOD. Unless I revoke this authorization on an earlier date, this authorization shall terminate on _____, or within six months from today's date, whichever occurs sooner.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving *written* notice stating my intent to revoke this authorization to the person or organization named in this authorization. I understand that my failure to sign this form or revoking this authorization cannot stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1).

AUTHORIZATION:

- I have read this form and agree to the uses and disclosures of the information as described.
- I understand I understand that treatment or payment *cannot* be conditioned on my signing this authorization and that I may be charged a retrieval/processing fee and for copies of my medical records.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.
- I hereby release the University of Houston System, each of its university components and departments, and any of their employees, officers, health care providers and agents from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE X_____ _____

Signature of Individual or Individual's Legally Authorized Representative **Date**

Printed Name of Legally Authorized Representative (if applicable):

_____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____

Signature of Minor Individual **Date**

FOR OFFICE USE ONLY			
_____	_____	_____	_____
Date Request Processed:	By:	Identification Presented:	Payment: