TEXAS SOUTHERN UNIVERITY

STUDENT HEALTH CENTER

3100 Cleburne Street

Houston, Texas 77004

(713) 313-7173 (phone) (713) 313-7817 (fax)

This request and authorization applies to opinions, evaluations, lab values, discharge summaries, progress notes, assessments, and any other information pertaining to treatments and services received or information maintained in the Student Health Center. All requests to release healthcare information, except request for copies of immunization records, are processed through the Office of General Counsel.

INSTRUCTIONS:

- **Complete Authorization to Release Healthcare Information Form**
- **Submit Copy of Student's driver's license or state issued identification card**
- **Request for copies of immunization records only can be completed at the Student Health Center**

MAIL COMPLETED FORMS TO THE OFFICE OF GENERAL COUNSEL:

TEXAS SOUTHERN UNIVERSISTY
Office of General Counsel
3100 CLEBURNE STREET
HOUSTON, TEXAS 77004
Or
Deliver to the Office of General Counsel in Hannah Hall, room 310

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Student's Name: _____ Date of Birth: _____

Previous Name: _____ Student ID#: _____

I request and authorize_____ to
Release/obtain healthcare information of the patient names above to:
(circle one)

Name: _____

Address: _____

City: _____*State:* _____ *Zip:* _____

Circle Delivery Method: Mail records Call for Pick up

This request and authorization applies to opinions, evaluations, lab values, discharge summaries, progress notes, assessments, and any other information which pertains to:

Healthcare information relating to specific treatment(s), condition(s), or date(s): _____

All healthcare information: _____

Yes/No I authorize the release of my STD results, HIV/AIDS testing, whether negative or Positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes/No I authorize the release of any records regarding drug, alcohol, or mental health Treatment to the person(s) listed above.

Student Signature: _____ Date Signed: _____

Witness: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED

For Office Use Only
Approval to release medical records: _____Date: _____
____Verify student's ID _____Copy of this request/release/disclosure form entered into student's record.