AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TEXAS A&M UNIVERSITY HEALTH

2900 E 29th St. Suite 100, Bryan, TX 77802 (P) 979-436-0447 (**F**) **877-601-5854**

Privacy Notice: The information on this form together with any attachments is the property of Texas A&M Health (TAMH). State Law requires that you be informed that you are entitled to: (1) request notification of the information collected about you by use of this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge to you.

Instructions: Please note that each section of this form must be completed in its entirely. Failure to specify (including dates) will delay the processing of your request. Allow 14 Business Days for Processing.

PATIENT

Patient Last Name	Patient First Name	Patient Middle Name	Date of Birth

RELEASED FROM

Name/Organization	Email Address	Phone
Address	**City, State, Zip Code**	**Fax**

Information may be: ☐ Mailed ☐ Faxed ☐ Phoned ☐ Emailed ☐ Picked up by Name: _____

RELEASED TO

Name/Organization	Email Address	Phone
Address	**City, State, Zip Code**	**Fax**

PURPOSE

Records are to be released for the following purpose(s): (Select all that apply)

☐ Medical Care ☐ Personal ☐ Other (specify): _____
☐ Insurance ☐ Legal/Attorney

INFORMATION TO RELEASE

Indicate types of records to be released : (Select all that apply)

☐ Entire Record ☐ Appointment History ☐ Radiology Reports
☐ Chart Summary ☐ Progress Notes ☐ Radiology Images
☐ Immunizations ☐ Lab Reports ☐ Operative Reports

☐ Other (specify):_____

PATIENT/ PARENT/LEGAL GUARDIAN AUTHORIZATION

Unless otherwise revoked, the Authorization will expire 60 days from the date it is signed or, if specified, on the following date: _____.

This Authorization may be revoked at any time. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Medical Records Department at the address below.

I, the undersigned, hereby authorize Texas A&M Health (TAMH) to use and/or disclose information from my (or given relationship) _____ medical or financial record as specified above. This authorization includes the use and/ or disclosure of information concerning HIV testing, any drug or alcohol abuse, drug-related conditions, alcoholism, and/ or mental health conditions to the above mentioned entity(ies). I agree not to hold TAMH, its employees, agents, officers, members, students, and participating health care providers responsible for lost, stolen, or otherwise misplaced medical information that cannot be reproduced.

Signature of Patient: _____ Date: _____

By signing the below, I verify that I have legal right(s) to obtain the requested medical information for the patient listed above.

Signature: _____ Date: _____
Parent/Legal Guardian/Spouse/Patient Representative

OFFICE USE ONLY

Request completed by: (PRINT NAME)	Signature	Date/Time
Released by: (PRINT NAME)	**Signature**	**Date/Time**
Witness (If released via telephone)	**Signature**	**Date/Time**