

Texas Tech University Health Sciences Center  
 PO Box 5066, 3601 4<sup>th</sup> Street, 1B108  
 Lubbock, TX 79408-5066  
 (806) 743-2608  
 1-888-300-9868

Patient Name: \_\_\_\_\_  
 TTUHSC MRN: \_\_\_\_\_  
 DOB/SSN: \_\_\_\_\_

**Authorization for Release of Patient Information**

I request and authorize Texas Tech University Health Sciences Center to:

- Release the following information to: Name of Facility/Person: \_\_\_\_\_
- Receive the following information from: Address /City, State, Zip: \_\_\_\_\_

<p><b>Release is for the Purpose of:</b></p> <input type="checkbox"/> Continued Care by other health care provider <input type="checkbox"/> Insurance <input type="checkbox"/> Attorney <input type="checkbox"/> Other (please specify) _____	<p><b>Information to be disclosed if requested:</b></p> <input type="checkbox"/> One Year <input type="checkbox"/> Two Years <input type="checkbox"/> Complete medical record <input type="checkbox"/> Billing statement <input type="checkbox"/> Specific Specialty _____ <input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Disability <input type="checkbox"/> School <input type="checkbox"/> Personal Review	<input type="checkbox"/> X-ray results <input type="checkbox"/> Lab results <input type="checkbox"/> Schedule <input type="checkbox"/> Immunization record

I understand and agree that the information I am authorizing to be released may include:

- (1) AIDS/HIV test results, diagnosis, treatment, and related information;
- (2) Drug screen results and information about drug and alcohol use and treatment;
- (3) Mental health information; and/ or
- (4) Genetics testing;

Unless otherwise requested \_\_\_\_\_.

<p>I further understand that this Authorization is voluntary and I may refuse to sign this Authorization. I further understand that my treatment will not be affected if I do not sign this form (45 C.F.R. 164.508 (c)(2)).</p> <p>I further understand that I may revoke this Authorization at any time by notifying the Texas Tech University Health Sciences Center (or the releasing facility) in writing, except to the extent that action has been taken in reliance on it. Unless earlier revoked, this Authorization expires automatically 90 days from the day signed or 90 days after the last TTUHSC clinic visit or after all insurance or third party claims have been paid or satisfactorily resolved, whichever occurs last (45 C.F.R. 164.508 (c)(2)).</p>	<p>I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.</p> <p>I further understand that I may refer to TTUHSC's Notice of Privacy Practices.</p> <p><b>RELEASE FROM LIABILITY</b> I release and agree to hold harmless TTUHSC Clinic (or other releasing facility) and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accord with this Authorization. I understand TTUHSC Clinic (or the releasing facility) cannot be responsible for use or re-disclosure of information to third parties (45 C.F.R. 164.508 (c)(2)).</p>	<p><b>TO THE RECEIVING PARTY OF THIS INFORMATION</b> This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation (42 C.F.R. Part 2).</p> <p>If the healthcare services (including examination and drug screening) are being provided at the request of and being paid for by my employer (or prospective employer), I understand and agree that all records and information related to the healthcare services provided to me may be given directly to my employer and if I wish to obtain such information, I should contact my employer/prospective employee.</p>
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I certify that this form has been fully explained to me, that I have read it or had it read to me\*, and that I understand its contents.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Patient/Other Legally Authorized Person

\_\_\_\_\_  
Witness/Translator\*

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Print name and relationship to patient