TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
at Amarillo

1400 S. Coulter, Room B600
Amarillo, Texas 79106
Phone: 806-414-9600 Fax: 806-354-5680

Texas Tech University Health Sciences Center **Patient Request for Access of Health Information**	Patient Name: _____ MRN: _____ DOB: _____

If you would like a copy of your medical record, please complete the form below.

Patient Name _____ Date of Birth: _____

Street Address _____ Last 4 numbers of SSN: _____

City, State, Zip: _____ Telephone: _____

Email address: _____

I would like for Texas Tech University Health Sciences Center (TTUHSC) to (choose one):

☐ Give me a copy of my health information

☐ Send my records to: ☐ Receive the information from:

_____
(Name of Facility, Person, Company) (Street address or PO Box, City, State, Zip Code)

_____
(Phone Number) (Fax Number)

_____
(Email Address)

I would like these dates of service to be released: _____

Information to be released:

Any and All records (complete record)

Only record types checked below:

Progress Notes/clinic notes	Schedule
Laboratory Reports	Other (please specify) _____
Immunization Record	Billing Records (dates)
Medication Record	Routine Record Set (Indicate date(s) of service _____ (office visits, lab, radiology, medicines, immunizations)

I agree that the following information may be released/used only as indicated below:

1. Aids/HIV test results, diagnosis, treatment, and related information Yes ☐ No ☐
2. Drug screen results and information about drug and alcohol use and treatment Yes ☐ No ☐
3. Mental health information Yes ☐ No ☐
4. Genetic testing Yes ☐ No ☐

I want these records as a (chose one):

☐ CD-encrypted – password_____ CD-unencrypted

☐ USB –encrypted – password _____ USB-unencrypted

☐ Electronic

☐ Paper copy

☐ Other: _____

I want you to (choose one):

☐ Mail them

☐ Send via email (encrypted)

☐ Send via email (unencrypted) * Not Currently Available

☐ Fax them to: _____

☐ Prepare them to be picked up by _____

If you request your medical record to be sent to you unencrypted via your personal mail, you acknowledge that your PHI is being transmitted through an unsecure means of communication.

Signature: _____ Print Name:_____

Relationship to Patient: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this document for the patient (Written Proof may be required)

To be completed by TTUHSC:

Date of release: _____ via ☐ Mail ☐ Fax ☐ Other_____

ID Verified DL/Other ID_____

Employee Name: _____ Date: _____

Email completed form to MedicalRecordsAmarillo@ttuhsc.edu or fax to 806.354.5680