Authorization for Release of Information
West Texas A&M University Student Medical Services
Fax 806-651-3289

Patient Name:_____ _____
Last, First Middle Buffalo Gold Card #

Date of Birth_____ Contact Telephone Number:_____

I hereby authorize Student Medical Services to release any or all information acquired during the course of my examination and/or treatment to the person(s) or agency specified below. I understand I have the right to revoke this authorization at any time. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Student Medical Services by calling (806) 651-3287.

_____ _____
Signature of Patient Date

Information to be released:

☐ Meningitis vaccine documentation only ☐ All Immunization Records
☐ All medical records This may include medical, social and psychiatric information, photocopies of my original medical record or information relating to sexually transmitted disease.
☐ Medical records from _____ (date)_____ pertaining to:
☐ Lab results regarding

Release this information to: ☐ Self (picking up in person)

☐ Release information to:_____

_____
Address City State Zip

☐ Fax this to: FAX #_____, ☐ E-mail to:_____ .