UHD DOWNTOWN

Student Health Services

Consent for Release of Confidential Information

Form Instructions:

1. Complete Form Online:

- Last Name, First Name, and Middle Initial (if applicable).
  (Name Changes: Include name used when attending UH-Downtown)
- Date-of-Birth
- Check appropriate request:
  - **Records generated prior to December 2006 could contain your social security number (SSN) and may be disclosed to the entity to which you are releasing your medical information. If you do not wish to release your SSN, request that the records be released to yourself by checking the "I will pick up records" or "Send records to me" box below. You can remove this information from your copy before releasing it to the entity requiring your medical information.**
  - FROM: Check if requesting records from UH-Downtown or other person/organization
  - TO: Check if requested records are to be released to UH-Downtown, self or other person/organization.
  - If records are to be sent, complete the name, address and/or phone and fax numbers.
    (Record requests over five pages cannot be faxed)
  - **Information to be released may include, but not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).**
- Check the type of records to be released. Request for complete medical records must include a payment of $20.00 at the time of request.
- Check the reason for records request.
- Form will automatically expire within 1 month of date completed. If desired, an alternate expiration date may be requested by entering the date you request the form will expired.
- Signatory Section:
  - Fill in the name of Patient or Legally Authorized Representative who will sign this form
  - Select the appropriate Relationship to Patient. If other, list relationship in the space provided.
  - Contact phone number
  - Date of request

2. Print Form

3. Sign Form

4. Send Completed Form, ID and Payment (if applicable) to Student Health Services:

- Send or bring completed Consent for Release of Confidential Information form to Student Health Services
  - Faxed/Mailed Form: Include a copy of your UH-Downtown ID or Driver License/State ID Card.
  - Delivering Form in Person: Present ID and form at check-in desk.
- **Requests for complete medical records**
  - Mailed requests should include a check or money order in the amount of ***$20.00***, payable to UH-Downtown, and a copy of VALID Driver's License or State ID.
    - Requests made in person may paid by cash, check or credit card.
    - Fax requests for complete medical records will not be accepted.
  - ***Authorized requests for complete medical records from another health facility will be processed at no charge. Forms may be sent by mail or fax. Records will be mailed directly to the health facility initiating the request.***
- Incomplete forms or forms received without valid ID and/or required payment (if applicable) cannot be processed.

5. Allow up to ten (10) business days for processing.

University of Houston-Downtown
Student Health Services

Consent for Release of Confidential Information

Please read all instructions and requirements prior to completing and sending form.

I authorize the following confidential health information to be released from the medical record of:

Last Name | First Name | MI | Date of Birth

Release Records From:

Records Released To:

University of Houston-Downtown
Student Health Services
One Main Street, Suite 455S
Houston, Texas 77002
Phone: 713-221-8137
Fax: 713-223-7419

Name:

Address:

Phone: Fax:

To be released:

- ☐ Clinician's Orders/Progress Notes
- ☐ Nurses' Notes
- ☐ Pap Smear Results
- ☐ Laboratory Results
- ☐ History & Physical
- ☐ Consultation/Referral Reports
- ☐ Mental Health Records
- ☐ Radiology Reports
- ☐ Other (list below)

For the purpose of:

- ☐ Continuing Medical Care
- ☐ Social Security/Disability
- ☐ School
- ☐ Insurance
- ☐ Personal Use
- ☐ Military
- ☐ Legal Purposes
- ☐ Other (list below)

_____ (Initial) I have read and understand the instructions and requirements for the Consent for Release of Confidential Information form.

_____ (Initial) I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

_____ (Initial) I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand I may be charged a retrieval/processing fee and for copies of my medical records. I understand my treatment will not be conditioned by my completion of this form. I understand that I may revoke this authorization in writing at any time except the extent that action has been taken in reliance upon the authorization.

_____ (Initial) If this authorization is not earlier revoked, this authorization shall terminate on _____, or within one month from today's date, whichever occurs sooner.

Signature of Patient or Legally Authorized Representative | Date

Printed Name of Patient or Legally Authorized Representative | Contact Phone Number

Relationship to Patient

To the third party receiving alcohol or drug abuse patient records: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part II. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Office Use Only

Release Sent: _____	Release Received:	ID Reviewed:	Payment Received: _____	Records Processed:_____
☐ Mailed ☐ Faxed	☐ Complete ☐ Incomplete	☐ Valid ☐ Invalid ☐ Not Sent ☐ NA	☐ Not Sent ☐ No Payment Required	☐ Mailed ☐ Faxed ☐ Ready for Pick-up