Authorization to Disclose Medical Record Information

Federal law says that your health information cannot be shared without your permission, except in certain situations. If you sign this form, you are giving the below-named institution permission to share your health information with the Texas Higher Education Coordinating Board.
This authorization is voluntary.

Patient Information

_____ _____ _____
Last Name First Name Middle Name or Initial

_____
Street City State Zip

_____ _____ _____ _____
Phone Date of Birth Age Social Security Number

Authorization

The undersigned hereby authorizes and requests: _____

To provide the Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711-2788 with access to my medical/healthcare records, as indicated below, for the purposes of review and examination, and further authorizes and requests the institution to provide such copies thereof as may be requested.

By his/her initials, the undersigned authorizes access and limits the request to the records below.

_____ 1. Confined to records regarding treatment for the following condition or injury:
(Initials)

_____

On or about: _____
Date(s) of service

_____2. Covering records for the period from _____ to _____
(Initials)

_____3. Confined to the following specified information:_____
(Initials)

_____4. I am unable to recall specific treatment dates. Please disclose the dates of any treatment I have received.
(Initials)

Expiration date of this authorization, if any:_____

_____ _____
Patient Signature Date

_____
(If signed by personal representative, state relationship.)

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