



Release of Medical Information

As a patient of the Sam Houston State University Health Center, you have the right for the contents of your medical records to remain confidential. The Student Health Center has taken several measures to protect your rights. Your medical records will not be released without this written consent unless required or allowed by law.

Please be aware that the Student Health Center is required to report positive laboratory test results for certain communicable diseases to the Texas Department of Health.

You must also take responsibility for maintaining the confidentiality of your medical information. Do not discuss or inquire about your medical conditions in common areas of the Student Health Center. The nurse will escort you to a room if you have a medical question or concern. Asking a question about a particular medical matter in a public area or divulging unsolicited medical information to non-medical staff could compromise the confidentiality of your medical information.

This consent allows the Student Health Center to share the contents of your medical records for treatment, payment, and health care operation purposes only. You have the right to deny or limit the release of your medical records. This consent does not allow for the release of your medical records for non-health related purposes unless otherwise specified.

Patient related information is shared on a need to know basis at the Student Health Center. In other words, your medical information is only shared with those employees that require the information to perform their job duties. The clerical, administrative, and medical staff members require varying degrees of access to your records while performing their job duties. If you have any concerns or questions regarding access to your medical records please feel free to ask.

You also have access to your medical records and may view them during the Student Health Center's hours of operation. You may also request for revisions to be made to your record. You may file a formal complaint regarding any breaches of confidentiality.

I authorize the release of my medical records for the aforementioned purposes. Additionally, I allow the release of my medical records as follows:

- 1. Release information to:

Specific entity or person Phone Fax

- 2. Regarding the treatment of the following medical condition(s):

- 3. For the period of: _____ to _____
Date Date

- 4. Confined to the following specified information:

- 5. Confined to a specific medical provider or entity:

- 6. Until a specified expiration date: _____

Patient Signature: _____

Date: _____