Authorization to Release Healthcare Information
Texas Christian University Health Center

Medical Director: **Jane Torgerson, MD**

Evelyn Tobias-Merrill, MD
Kerri Waldron, MD
Beth Wieser, DO
Daralynn Deardorff, DO
Holly Coker, PA-C
Amy De La Rosa, PA-C
Johnnie Ireland, WHNP
Kim Mercer, DNP,APRN,PMHNP-BC,FNP-BC

NAME OF PATIENT OR INDIVIDUAL

_____

Last **First** **Middle**

Other Name(s) Used _____

Date of Birth: Month _____ Day _____ Year _____

Address _____

_____

City _____ State _____ Zip _____

Phone (____) _____ Mobile (____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

___ Treatment/Continuing Medical Care
___ Personal Use
___ Billing or Claims
___ Insurance
___ Legal Purposes
___ Disability Determination
___ School
___ Employment
___ Other _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE MY PROTECTED HEALTH INFORMATION:

Person/Organization Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. If all health information is to be released check only the first box.

□ All Health Information □ Radiology Reports/Images □ Consultation Reports
□ Pathology Reports □ EKG/Cardiology Reports □ Immunizations
□ Lab Results □ Past/Present Medications □ Billing Information □ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Drug, Alcohol or Substance Abuse Records
_____ Genetic Information (Including Genetic Test Results) _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. If not previously revoked, this authorization will remain valid until the later of 180 dates from the date signed below, or the following date/event: _____

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by sending a written revocation to the Texas Christian University Health Center at one of the addresses (mail, fax or e-mail) identified below. I understand that prior actions taken in reliance on this authorization by the Texas Christian University Health Center will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization is subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE: _____ **DATE:** _____

YOU MAY SUBMIT THIS COMPLETED FORM BY:

Fax: 817-257-7279 **Mail:** TCU Box 297400, Fort Worth, TX 76129 **E-Mail:** healthinfo@tcu.edu