



Authorization to Release Healthcare Information
Texas Christian University Health Center

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NAME OF PATIENT OR INDIVIDUAL

REASON FOR DISCLOSURE
(Choose only one option below)

Last First Middle
Other Name(s) Used
Date of Birth: Month Day Year
Address
City State Zip
Phone () Mobile ()

- 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 TCU Health Center
Address Texas Christian University, P.O. Box 297400
City Fort Worth State TX Zip Code 76109
Phone (817) 257-7940 Fax (817) 257-7279

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

Your initials are required to release the following information:

Mental Health Records (excluding psychotherapy notes)
Genetic Information (Including Genetic Test Results)
Drug, Alcohol or Substance Abuse Records
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