Texas Tech University Health Sciences Center
Department of Medical Records
4241 North Tanglewood
Odessa, TX 79762
(432) 368-3185

Patient Name: _____

TTUHSC MRN: _____

DOB: _____

Authorization for Release of Patient Information

I authorize Texas Tech University Health Sciences Center to:

☐ Release the following information to: Name of Facility/Person: _____

☐ Receive the following information from: Address /City, State, Zip: _____

Release is for the Purpose of:	**Information to be disclosed/used:**
☐ Continued Care by other health care provider	☐ Disability
☐ School	☐ Complete medical record
☐ X-ray results	☐ Insurance
☐ One Year	☐ Lab results
☐ Personal Review	☐ Immunization record
☐ Schedule	☐ Attorney
☐ Billing Statements (Dates):_____	☐ Other (please specify) _____
☐ Specific Specialty _____	☐ Other (please specify) _____

I agree that the following information may be released/used only as indicated below:

(1) AIDS/HIV test results, diagnosis, treatment, and related information ***yes*** ___ ***no*** ___
(2) Drug screen results and information about drug and alcohol use and treatment ***yes*** ___ ***no*** ___
(3) Mental health information ***yes*** ___ ***no*** ___
(4) Genetics testing ***yes*** ___ ***no*** ___

ACKNOWLEDGMENTS:
I understand that:

1. This Authorization is voluntary and I may refuse to sign it. My treatment or payment for services will not be affected if I do not sign this Authorization.

2. If I want to cancel this Authorization I must submit a written notice to the Texas Tech University Health Sciences Center (or the releasing facility). Information may be released until my written notice of cancellation is received.

3. This Authorization expires 180 days from the date signed or on the following date or event (specify):_____.

4. Additional information is in TTUHSC' s Notice of Privacy Practices.

5. If the healthcare services are being provided at the request of and being paid for by my employer (or prospective employer), I understand and agree that all records and information related to the healthcare services provided to me may be given directly to my employer and if I wish to obtain such information, I must contact my employer/prospective employer.

TO THE RECEIVING PARTY OF THIS INFORMATION

This information has been disclosed to you for the sole purpose(s) stated in this Authorization.
Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation . Federal rules prohibit you from making further disclosure unless you have received written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

RELEASE FROM LIABILITY
I release and agree to hold harmless TTUHSC Clinic (or other releasing facility) and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accord with this Authorization. I understand TTUHSC Clinic (or the releasing facility) cannot be responsible for use or re-disclosure of information to third parties.

I certify that this form has been fully explained to me, that I have read it or had it read to me*, and that I understand its contents.

_____	_____	_____
Date	Time	Patient/Other Legally Authorized Person
_____	_____	_____
Witness/Translator*	Print name	Print name and relationship to patient