TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Department of Ophthalmology
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Authorization To Release and Disclose Patient Information

PATIENT INFORMATION TTUHSC MRN:_____	PATIENT NAME: _____ DATE OF BIRTH:_____ Address:_____ Day Phone:_____ City:_____ State:_____ Zip:_____
RECEIVING PARTY ☐ **Send** the information to: ☐ **Receive** the information from:	NAME:_____ Address:_____ Phone:_____ City:_____ State:_____ Zip:_____
INFORMATION TO BE RELEASED (**What** do you want sent or **released**? Check the appropriate box.)	☐Any and All records (complete record) **Only records types checked below**: ☐Progress notes/clinic notes ☐ Schedule ☐Laboratory reports ☐Other (please specify)_____ ☐Immunization record ☐Billing Records (dates) _____ ☐Medication record ☐Routine Record Set (indicate date(s) of service_____) (office visit, lab, radiology, medicines, immunizations) **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. Genetic testing Yes___ No___
RELEASE INSTRUCTIONS (**How** do you want the information?)	☐Paper ☐Electronic Form (CD/USB)
PURPOSE OF RELEASE (Why is it needed?)	☐Continuing Care by other health care provider ☐Disability ☐ School ☐Insurance ☐Personal review ☐Attorney/Legal ☐Other_____
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 further disclosure unless you have received written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

- 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.
- This Authorization may be canceled by submitting a written notice to Texas Tech University Health Sciences Center (or the releasing facility). Information may be released until my written notice of cancellation is received.
- **This Authorization expires 180 days from the date signed or on the following date or event (specify)** _____
- Additional information is in TTUHSC's Notice of Privacy Practice.
- 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.

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

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

Date _____ Print Your Name _____ Patient or Legally Authorized Signature _____

Time _____ Witness/Translator * _____ Relationship to patient _____