PO Box 5066, 3601 4th St., 1B108
Lubbock, Texas 79430-5066
806-743-2608 or toll free: 1-800-300-9868

Texas Tech University Health Sciences Center **Patient Request for Access of Health Information**	Patient Name: _____ MRN: _____ DOB: _____

If you would like a copy of your medical record, please complete the form below.

Patient Name _____ Date of Birth: _____
Street Address _____ Last 4 numbers of SSN: _____
City, State, Zip: _____ Telephone: _____
Email address: _____

I would like for Texas Tech University Health Sciences Center (TTUHSC) to (choose one):
☐ Give me a copy of my health information
☒ Send my records to: ☐ Receive the information from:

Study Abroad Office TTU — 601 Indiana Avenue, MS 5004 Lubbock, TX 79409
(Name of Facility, Person, Company) (Street address or PO Box, City, State, Zip Code)
(806) 742-3667 (Fax Number)
(Phone Number)
studyabroad@ttu.edu
(Email Address)

I would like these dates of service to be released: _____

Information to be released: If applicable, records may be released to a third party ✓

☐ Any and All records (complete record)
Only record types checked below:
☐ Progress Notes/clinic notes ☐ Schedule
☐ Laboratory Reports ☑ Other (please specify) Travel Physical and Health History Forms
☐ Immunization Record ☐ Billing Records (dates)
☐ Medication Record ☐ Routine Record Set (Indicate date(s) of service _____
(office visits, 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 X No ____
2. Drug screen results and information about drug and alcohol use and treatment — Yes X No ____
3. Mental health information — Yes X No ____
4. Generic testing — Yes X No ____

I want these records as a (chose one):
☐ CD-encrypted – password_____ ☐ CD-unencrypted
☐ USB –encrypted – password _____ ☐ USB-unencrypted
☐ Electronic
☑ Paper copy
☐ Other: _____

I want you to (choose one):
☑ Mail them
☐ Send via email (encrypted)
☐ Send via email (unencrypted)
☐ Fax them to: _____
☐ Prepare them to be picked up by _____

If you request your medical record to be sent to you unencrypted via your personal mail, you acknowledge that your PHI is being transmitted through an unsecure means of communication.

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this document for the patient (Written Proof may be required)

To be completed by TTUHSC:
Date of release: _____ via ☐ Mail ☐ Fax ☐Other_____
☐ID Verified ☐ DL/Other ID_____
Employee Name: _____ Date: _____