



TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

PO Box 5066, 3601 4th St., 1B108
Lubbock, TX 79430-5066
806-743-2608
1-888-300-9868 Toll Free

Authorization to Release and Disclose Patient Information

PATIENT INFORMATION TTUHSC MRN: _____	PATIENT NAME: _____ DATE OF BIRTH: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
RECEIVING PARTY <input checked="" type="checkbox"/> Send the information to: <input type="checkbox"/> Receive the information from:	NAME: _____ LUBBOCK PRIVATE DEFENDERS OFFICE Address: _____ 1401 Crickets Ave Phone: _____ 806-749-0007 City: _____ LUBBOCK State: _____ TX Zip: _____ 79401
INFORMATION TO BE RELEASED (What do you want sent or released? Check the appropriate box.)	<input checked="" type="checkbox"/> Any and All records (complete record) <u>Only records types checked below:</u> <input type="checkbox"/> Progress notes/clinic notes <input type="checkbox"/> Schedule <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Other (please specify) _____ <input type="checkbox"/> Immunization record <input type="checkbox"/> Billing Records (dates) _____ <input type="checkbox"/> Medication record <input type="checkbox"/> 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 <input checked="" type="checkbox"/> No _____ 2. Drug screen results and information about drug and alcohol use and treatment Yes <input checked="" type="checkbox"/> No _____ 3. Mental health information Yes <input checked="" type="checkbox"/> No _____ 4. Genetic testing Yes <input checked="" type="checkbox"/> No _____
RELEASE INSTRUCTIONS (How do you want the information?)	<input checked="" type="checkbox"/> Electronic Form (CD/USB preferred method) <input type="checkbox"/> Paper
PURPOSE OF RELEASE (Why is it needed?)	<input type="checkbox"/> Continuing Care by other health care provider <input type="checkbox"/> Disability <input type="checkbox"/> School <input type="checkbox"/> Insurance <input type="checkbox"/> Personal review <input checked="" type="checkbox"/> Attorney/Legal <input type="checkbox"/> 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.
<ul style="list-style-type: none"> • 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) 1 YR FROM SIGNATURE DATE • 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. <p>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.</p>	

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 (Person signing consent form)	Patient or Legally Authorized Signature
		SELF
Time	Witness/Translator *	Relationship to patient