ST. MARY'S UNIVERSITY

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

StMU ID#: _____ SS#: xxx-xx-_____ Phone #: _____

Medical Records can be mailed or sent by fax ONLY. We do not email medical records

Information Released From: St. Mary's University
Student Health Center
One Camino Santa Maria, #45
San Antonio, Texas 78228
210-436-3506 main line / 210-436-3656 fax line

Information Released To:

Name: _____

Address: _____

City/State/Zip: _____

Fax #: _____

Please Release the Following:

_____ Problem List
_____ Progress Notes
_____ History/Physical Exam
_____ Lab Reports
_____ Immunizations
_____ X-Ray Reports
_____ X-Ray Films
_____ EKG Reports
_____ Other Diagnostic Reports (Specify) _____
_____ Other (Specify) _____

Including information (if applicable) pertaining to:
_____ Mental Health _____Drug/Alcohol _____HIV/AIDS _____Communicable Treatment

Purpose of Need for Disclosure:

_____Continued Patient Care
_____ Attorney/Legal
_____ Disability Determination
_____ Personal Use
_____ Insurance Claim/Application
_____ Other (Specify)

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold St. Mary's University Student Health Center liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative:_____Date:_____

Relationship to Patient: _____ Witness: _____

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For Student Health Center Staff Use Only: Date request completed_____ # pages copied _____ Initials _____