

West Texas A&M University
Authorization for Release of Information

Patient Name:_____

Last, First, Middle

(Any other name at time of visit)_____

Social Security #_____ - _____ - _____

Date of Birth_____

MM/DD/YY

I hereby authorize Student Medical Services to release any or all information acquired during the course of my examination and/or treatment to the person(s) or agency specified below. This may include medical, social and psychiatric information. It may include photocopies of my original medical record.

Signature of Patient

Information to be released:

_____All medical records.

_____Medical Records regarding: _____

_____Lab results regarding_____

_____X-ray results regarding_____

_____Other_____

Covering treatment from _____ to _____

Release this information to:

_____ Self

_____Will pick up or

_____Mail to: Address:_____, City_____,

State_____, Zip_____

or mail this to:

____ Name of Person, Medical Provider or

Agency_____

Address_____, City_____,

State_____Zip_____

Or Fax this to:FAX #_____,

telephone number_____

Name of person or facility_____