Authorization for Release of Information

Patient Name:_____ _____
Last, First Middle Buffalo Gold Card #

Date of Birth_____ Contact Telephone Number:_____

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, photocopies of my original medical record or information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS, or human immunodeficiency virus (HIV). I understand I have the right to revoke this authorization at any time. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Student Medical Services by calling (806) 651-3287.

_____ _____
Signature of Patient Date

Information to be released:

☐ Meningitis vaccine documentation only ☐ All Immunization Records
☐ All medical records
☐ Medical records from _____ (date)_____ pertaining to:
☐ Lab results regarding

Release this information to: ☐ Self (picking up in person)

☐ Release information to:_____

_____
Address City State Zip

☐ Fax this to: FAX #_____, ☐ E-mail to:_____ .