West Texas A&M University, Student Medical Services
WTAMU Box 61401, Canyon, TX 79016,
Phone (806)-651-3287 FAX (806) 651-3289

Request for Information ***Please print legibly.***

To: Provider/Health Care Facility_____

Provider's _____

Address City State Zip

Provider's _____ _____

Phone Number Fax Number

Student Medical Services is requesting medical records on the patient listed below. Please include the items indicated.

____All Medical Records

_____Medical Records from _____ to ____

History and Physical

____Lab Reports _____

____X-ray Reports _____

____Cat Scan/MRI Scan

____Pap Pathology Report (recent)

____Other_____

____Birth Control Prescription

(we sell Desogen/Solia & Depo Provera)

____Please forward the information to: *West Texas A&M University, Student Medical Services*
WTAMU Box 61401 Canyon, TX 79016 or call (806) 651-3287

____Please fax the information to **(806) 651-3289_____ASAP**

Patient Full Name_____

Last, First, Middle and/or (any other name used)

Buffalo Gold Card # _____ Last 4 of Social Security Number_____

DOB:_____

Approximate Dates of Treatment_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS, or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This type of sensitive information will only be released if specifically requested by checking "other" above and stating exactly what information is to be released.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. 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. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 180 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. 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.

I hereby authorize the above named provider/facility to release any or all information from my records in their possession to West Texas A&M University Student Medical Services. This may include medical records, lab reports, HIV lab reports, and prescriptions, social, psychiatric or scholastic and counseling evaluation. It may include photocopies of my original medical record.

_____ _____

Signature Date