Baylor University Health Services
ATTN: Records Request/Release
One Bear Place #97060
Waco TX 76798-7060
Telephone (254) 710-1010 Fax (254) 710-2499 E-mail: Health_Services@baylor.edu

BAYLOR UNIVERSITY

CONSENT/AUTHORIZATION TO ACCESS OR RELEASE PROTECTED HEALTH INFORMATION (PHI)

Last Name (Please Print) First Middle Maiden Name

Date of Birth Baylor ID # Phone Number

Are you currently enrolled in classes at Baylor? ____ Yes ____ No If no, give semester and year that you last attended_____

When you were a student, were you treated in the Baylor Health Center? ____Yes ___ No (Former students see payment requirement below)

PLEASE NOTE: For PHI requested from Baylor University Health Services, the Medical Records will be copied. All records from outside providers are excluded.

☐ I request that Baylor University Health Services release my records to the following person or facility:
☐ I request that the facility below release my records to Baylor University Health Services.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

CHECK ALL BOXES THAT APPLY

☐ Limited to records regarding specific illness/injury/mental health (state condition or approximate dates).

☐ All Medical Records ☐ Immunization Record ☐ Billing * ☐ Lab * ☐ X-Ray report * ☐ Progress Notes*
☐ ADHD Evaluation
☐ Other *From _____ (date) To _____ (date)

PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSE(S):
☐Consultation Referral ☐Another Care Provider ☐Attorney ☐Personal Records ☐Insurance
☐Other

☐ I understand there is a charge for records provided to former students: $5.00 for Immunization Record or $15.00 for All Medical Records (which includes Immunization Record). Payment must be made by cash, check or money order payable to Baylor University Health Services and mailed with this completed form. Credit card payments accepted via telephone after completed form has been submitted via fax or e-mail.

1. ***I understand the information to be released may include information regarding the diagnosis or treatment of HIV (AIDS virus) or other sexually transmitted diseases, mental health or psychiatric treatment, or drug and alcohol education and treatment records. I give my specific authorization to release all health care information relating to such diagnosis, testing or treatment.***
2. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. Baylor University Health Services personnel will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: 1) if my treatment is related to research, or, 2) health care services are provided to be solely for the purpose of creating PHI for disclosure to a third party.
3. I understand that I may cancel this authorization in writing at any time, except to the extent that action has already been taken to comply or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Without my express cancellation, this authorization will automatically expire upon satisfaction of the need for disclosure, not to exceed 180 days from date of signature. I understand this authorization will not apply to care provided after date of my signature.
4. The Board of Regents of Baylor University, Baylor University and Baylor University Health Services will not be responsible for recipient's disclosure of information released pursuant to this authorization.
5. I understand the potential for information that is disclosed pursuant to this authorization to be re-disclosed by the recipient and no longer protected by federal or state law.
6. A copy or facsimile may be utilized with the same effectiveness as an original.

I have read and acknowledge that I understand the terms and conditions of this request. I release both facilities from any liability complying with this request.

Signature of Patient/Client (or Personal Representative—include relationship to patient) Date

Witness Date

To Recipient: This information has been disclosed to you from records whose confidentiality may be protected by federal and state laws or regulations, which may prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such laws or regulations. A general authorization for release of medical or other information is NOT sufficient for this purpose.

Request/Release completed by_____ on _____

Revised September 2013