AUTHORIZATION TO DISCLOSE MEDICAL RECORD INFORMATION
(Includes Investigation/Copying of Medical Records)

- Federal law says that your health information cannot be shared without your permission, except in certain situations. If you sign this form, you are giving the below-named institution permission to share your health information with the Texas Higher Education Coordinating Board.
- This authorization is voluntary.

_____ _____ _____
Patient Name (Last) (First) (Middle)

_____ ____ _____ _____
Date of Birth Age Social Security Number Phone Number

_____
Patient Address

The undersigned hereby authorizes and requests:

_____
(Name of institution)

To provide the Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711-2788 with access to my medical/healthcare records, as indicated below, for the purposes of review and examination, and further authorizes and requests the institution to provide such copies thereof as may be requested.

By his/her initials, the undersigned authorizes access and limits the request to the records below.

_____ 1. Confined to records regarding treatment for the following condition or injury:
Initials

_____

On or about: _____
Date(s) of service

_____ 2. Covering records for the period from _____ to _____
Initials Date Date

_____ 3. Confined to the following specified information: _____
Initials

_____ 4. I am unable to recall specific treatment dates. Please disclose the dates of any
Initials treatment I have received.

Expiration date of this authorization, if any: _____

_____ _____
Patient Signature (if signed by personal representative, state relationship) Date