University of North Texas Health Science Center at Fort Worth

STUDENT AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Student _____ **DOB:** _____

I authorize the University of North Texas Health Science Center at Fort Worth (UNTHSC) to obtain and release the protected health information described below.

I understand that signing this authorization is voluntary and is not a condition for treatment, enrollment in a health plan, or eligibility for benefits. I understand that I have the right to revoke this authorization at any time by providing a signed, written notice of such revocation to the UNTHSC Student Health Clinic. I understand that a description of my right to revoke my authorization is set forth in UNTHSC Notice of Privacy Practices.

I understand the information released pursuant to this authorization may no longer be protected by law or regulation and may be re-disclosed by the recipient.

1. Please use or disclose the following health information, if such information exists:

   A. Immunization Records
   B. Antibody test results, obtained via laboratory, related to immunizations
   C. Tuberculosis skin testing (PPD) and any subsequent evaluation for PPD tests that are determined to be positive
   D. Physical examinations that are necessary to meet the requirements for clinical rotations

2. The information is to be used in my capacity as a student at UNTHSC or in a medical residency program affiliated with UNTHSC and may be disclosed, as needed, in order for me to participate in clinical rotations at the various health care facilities.

This authorization remains in effect as long as the Student is enrolled at or in a medical residency program affiliated with the University of North Texas Health Science Center at Fort Worth, unless revoked on an earlier date by the students providing a signed, written notice of such revocation.

_____ _____

Signature of Student or Representative Date

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Print Name and Relationship, if applicable