RELEASE OF MEDICAL RECORDS
TO THE
UNIVERSITY OF NORTH TEXAS
STUDENT HEALTH & WELLNESS CENTER

TO: ____ ____________________________

Medical Provider (Doctor, Clinic, etc.) — Provider phone number

____

Street Address or P.O. Box Number

____ ____________________________

City State Zip Code — Provider fax number

I, ____ ____________________________

(Print Name) Last First M.I. (Date of Birth)

authorize the release of (circle one of the following) **Partial/Complete** copies of my medical records including reports, opinions, evaluations, and any other information, which pertains to the medical care, I have received at your facility.

AIDS/HIV Infection information is within scope of the release, unless exception is noted:

____.

Alcohol and Drug Use information and/or treatment for Alcohol or Drug Use are within the scope of this release unless exception is noted: ____

____.

Mental Health information is within the scope of this release, unless exception is noted:

____.

If partial was circled, then identify the specific records to be released:

____

____.

Reason/Purpose for release: ____

This release/event will expire on: ____________________________________

Release records to the address on the right:

Medical Records Department/Student Health & Wellness Center
University of North Texas
ATTN: ______________________________
(Doctor's Name)

1155 Union Circle #305160
Denton, TX 76203-5017
Fax: (940) 369-7042

Signature of Patient: ____

Date: ______________________

Legal representative of patient: ____

Relation to patient: ________________________________ Date: __________________

Revised 08/10/17