

# UNT STUDENT HEALTH & WELLNESS CENTER REQUEST/RELEASE/DISCLOSURE of MEDICAL RECORDS

I \_\_\_\_\_  
(Print name) (UNT Student #) (Date of Birth)

do authorize the UNT Student Health and Wellness Center to release(Circle one of the following) **Partial/Complete** copies of my medical records including reports, opinions, evaluations, and any other information which pertains to my medical care or to exchange information regarding my medical care.

**AIDS/HIV Infection** information is within the scope of this release, unless exception is noted:  
\_\_\_\_\_.

**ALCOHOL and Drug Use** information and/or treatment or Alcohol or Drug Use 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 record to be released; or the information, which can be verbally shared:  
\_\_\_\_\_.

Reason/Purpose for release: Personal Records; Specialist; Insurance; Other: \_\_\_\_\_  
(Please circle or identify)

Please release records to myself \_\_\_\_\_  
Or the person named to the right Self/Doctor/Insurance/Other

And/or mail to the destination referenced \_\_\_\_\_  
On the right. Street Address or PO Box

City State Zip Code

The above authorization is to be in effect until such time as I revoke it in writing. An original authorization or photocopy thereof, will authorize release of all of the information requested above.

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

Failure to provide the required information for release of copies will result in the form being returned for completion. There is a 10 working day period from the date a properly executed release is received until copies are sent.

**(Bottom Portion Medical Records Office Use)**

\_\_\_\_\_  
(print name) Last First MI  
Date of Birth \_\_\_\_\_ Patient Telephone No \_\_\_\_\_ Amount Due \_\_\_\_\_ Copied By: \_\_\_\_\_

Approval to release Medical Records \_\_\_\_\_ (Date: \_\_\_\_\_  
Records Supervisor or Medical Provider

\_\_\_\_\_ Verify Patients Picture Identification \_\_\_\_\_ Scan Request/Release/Disclosure form into patient's EMR.