Authorization to RELEASE Protected Health Information

COLLEGE OF PUBLIC AFFAIRS & COMMUNITY SERVICE UNT
Speech & Hearing Center

This form, if signed, will authorize the UNT Speech and Hearing Center (SHC) to use and release certain health information about the person named below. All items must be completed and the authorization signed and dated by an authorized person to be valid. I understand this authorization is voluntary. I may refuse to sign this authorization and I understand that SHC may not withhold treatment because I refuse to sign this authorization.

I authorize UNT Speech and Hearing Center to release health information, as described below, from the chart of:

Patient's Full Name: _____ **Date of Birth**: _____

2. The information specified below may be released to:

Name/Company: _____

Address: _____ Telephone: _____

City: _____State: _____ Zip: _____

3. The specific purpose(s) for this disclosure is/are [check (√) your selection(s)]: ☐my records ☐share with other healthcare providers; ☐social security /disability; ☐military; ☐education; ☐insurance ☐other _____

4. Must select one: ☐ I consent **OR** ☐ I do not consent for the specified information to be released to include history, diagnosis and/or treatment for: HIV/AIDS/testing, communicable diseases, Drugs/Alcohol, Mental Health disease.

5. SPECIFY EXACT INFORMATION TO BE RELEASED: Please indicate if you are requesting Audiology or Speech-Language Pathology records to be released, and the date(s) of the record you are requesting.

☐ Audiology Date(s): _____

☐ Speech-Language Pathology Date(s):_____

I approve verbal communication with: _____for visit date(s): _____Initial: _____

6. I understand and acknowledge the following statements: I may be asked to show proof that I have the authority to sign an authorization to review, receive or release to another party copies of the above named patient's medical record which I am requesting. Unless required or allowed by law, the medical information will not be released to another party. After the above medical information is released, it may be re-released by the recipient and the information may no longer be protected by federal privacy laws or regulations. A facsimile or photocopy of this authorization is as valid as the original. I may revoke this authorization at any time by notifying UNT SHC in writing of my intent to revoke this authorization. If I do notify UNT SHC in writing of my intent to revoke this authorization, such revocation will not have any effect on any actions by UNT SHC taken before the revocation. Unless otherwise revoked in writing, this authorization will EXPIRE 365 DAYS from the date this form is signed.

7. _____ _____
Date Signature of Patient, Parent or Legally Authorized Representative

_____ _____
Printed Name of Patient, Parent or Legally Authorized Representative Relationship

Physical Address
907 W. Sycamore
Denton, TX 76201
Phone: (940) 565-2262

UNT Speech & Hearing Center

Mailing Address
1155 Union Circle #305010
Denton, TX 76203-5017
Fax: (940) 369-7702