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

I _____ _____
(Print name) **(**UNT ID#) (Date of Birth)

I 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. This information may be subject to re-disclosure by the recipient – it is not protected by this release.

This release will expire on: Date:_____
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.

Revised: 08/11/2017