MSU TEXAS
MIDWESTERN STATE UNIVERSITY

AUTHORIZATION FOR RELEASE OF INFORMATION

Vinson Health Center

Patient's Name: (print) _____ Phone: _____

Address: _____

Mustangs ID No: _____ Date of Birth: _____

1. Information to be Released:

_____ Copy of entire medical record (This will include drug, alcohol, mental health or comunicable disease related information such as HIV [AIDS] test results, if any)

_____ Include copies of documents which were not done at the Vinson Health Center (e.g., Hospital records, outside lab and x-ray test, etc)

_____ Other (specify) _____

_____

2. Requesting Records from: **Name of clinic and physician with phone and fax #**

_____

3. The above information may be released to: **Vinson Health Center, 3410 Taft Blvd**

Wichita Falls, TX 76308 Phone: 940-397-4231 Fax: 940-397-4504

4. The reason for release of information is (please be specific):

_____

_____

5. I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.

6. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and that, in any event, this authorization expires automatically as described below.

7. This authorization will expire sixty (60) days from the date of my signature unless otherwise specified by date, event, or condition as follows:

DATE: _____ SIGNATURE: _____

(Patient or legal representative)

WITNESS: _____