

Student Health Center
Tarleton State University
Box T – 0360
Stephenville, Texas 76402
(254) 968-9271
Fax (254) 968-9710

I, _____, (_____)
First Middle Last (Maiden) SSN

Date of Birth

hereby authorize the release of my records for my most recent examination and latest pap smear results from:

Physician's Name

Street Address

City State Zip

Phone Number Fax Number

to: Tarleton State University Student Health Center
Box T-0360
Stephenville, TX 76402
(254) 968-9271
Fax (254) 968-9710

This information may be sent by FAX

The release is in effect for 6 months from the date of my signature. I have the right to revoke this authorization in writing by letter or FAX to the TSU SHC at any time. This information will be used for treatment, not for insurance purposes. There is potential for this information to be subject to re-disclosure by the recipient and no longer be protected by this policy. If this form is not signed, I will be responsible for obtaining the records from my physician.

Client Signature Date

This release will expire on: _____

