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 medical records from Tarleton State University to:

____

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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

____________________________ ____________________________

Custodian of Records Date

This release will expire on: ____