Authorization for Release of Medical Records

Patient's Name: (print) _____
(Print) First Middle Last

Phone: _____ Email: _____

UMHB Student ID#: _____ Date of Birth: _____

1. Information to be released:

   Immunization Record (check all that apply)

   ____ Meningitis ____ TB Skin Test ____ FLU

   Other (specify) _____

2. Requesting Records from:

   University of Mary Hardin-Baylor Health Center
   Office: (254) 295-4696
   healthservices@umhb.edu

3. The above information will be released to myself to the email provided.
   Keep a copy for your records. Scan/Take a picture of the record and save it to your computer or phone.

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. Keep a copy of your records for future use.

6. I also understand that I may revoke this authorization at any time except to 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.

I authorize immediate release of my Report of Medical history and Immunizations from the University of Mary Hardin-Baylor Health Center to the above named party. I am aware processing may take 2-14 business days.

Date: _____ SIGNATURE: _____
(Patient or Legal Representative)