Tennessee Tech University Name:_____
Student Health Services SSN:_____
P O Box 5096 DOB:_____
Cookeville, TN 38505 Phone:_____
Phone (931) 372-3320
Fax (931) 372-3848

<u>**Receiving**</u> **Medical Records at TTU Health Services**

TO: _____

_____

_____

I, _____, hereby authorize the release of the following information to the **Student Health, Tennessee Tech University, Cookeville, TN.** Fax number (931) 372-3848. Please send the records to the attention of_____.

_____Initial evaluation _____Entire medical record

_____Progress Notes _____History and Physical

_____Consultation Reports _____Psychological testing

_____Discharge/treatment summary _____Immunization Records

_____TB skin test _____Women's Health notes

_____Allergy shot information _____Laboratory/Cytology reports

I further authorize you to discuss the above noted information with _____ at the Student Health Services.

I understand that my information may be re-disclosed by the authorized person/organization receiving the information, and at that point, the information may be no longer be protected under the terms of this agreement.

I understand that treatment, payment, enrollment, or eligibility in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization.

I understand that by refusing to sign this authorization may result in the doctor declining to provide the health care, which is for the sole purpose of creating protected health information for disclosure to a third party. Patient Initials:_____

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to the **Student Health Services** to disclose my records, and that I may revoke this Authorization in writing at any time. This consent form will expire one (1) year following the date signed or upon my request.

Signature_____

Date_____

*The above authorization is given on this patient's behalf because the patient is a minor, or is unable to sign for the following

reason:_____

_____

Date_____
*Signature of Closest Relative or Legal Guardian (state relationship)