

Tennessee Tech University  
Student Health Service  
SSN: \_\_\_\_\_  
PO Box 5096  
DOB: \_\_\_\_\_  
Cookeville, TN 38505  
Phone: \_\_\_\_\_  
Fax (931) 372-3848

Name \_\_\_\_\_

Phone (931) 372-3320

**SENDING OR DISCLOSING HEALTH INFORMATION BY TTU: Student Health Services**

I authorize the Student Health Services at Tennessee Tech University, Cookeville, TN, to use or disclose the above name individual's health information as described below: The following information is to be disclosed:

Entire Record  Immunization Record  
 Lab results. Please list test (s)/date (s) \_\_\_\_\_  
 X-ray and imaging reports. Please list test (s)/date (s) \_\_\_\_\_  
 Last visit. Please state date of service \_\_\_\_\_  
 Other (Please specify date (s) of service or specific information) \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse. I do NOT authorize Student Health Services to disclose any of the following information:

AIDS/HIV  Alcohol/Drug Abuse  Sexually Transmitted Diseases  Behavioral/Mental Health

This information may be disclosed to and used by the following individual or organization:

Name/Organization \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Purpose of disclosure:  At the request of the individual  Other \_\_\_\_\_

I will pick up the copies myself (please allow 24 hours to process and please bring picture ID to pick up).  Please mail the copies to the address listed above.

**THIS AUTHORIZATION DOES NOT EXTEND TO RECORDS MAINTAINED BY TTU'S GUIDANCE AND COUNSELING CENTER.**

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization. However, TTU Health Services may deem the provision of health care for the purpose of disclosing to a third party protected health information specifically created for that third party, or for participating in research related treatment, upon my agreement to use and disclose this information.

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 at any time by providing a written notice to the Student Health Services to the attention of Medical Records. The revocation shall be effective except to the extent that SHS has already used or disclosed information from the Authorization. I understand that my information may be re-disclosed by the Authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. Unless otherwise revoked, this

authorization will expire on the following date, event or  
condition: \_\_\_\_\_  
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 reasons: \_\_\_\_\_

Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Relative/Guardian/Personal representative

Date copy given to patient \_\_\_\_\_ Processed  
by \_\_\_\_\_ Date \_\_\_\_\_