STEPHEN F. AUSTIN
STATE UNIVERSITY
Health and Wellness Hub

AUTHORIZATION TO RECEIVE OR TO RELEASE INFORMATION

Please be advised that your medical health records constitute privileged information that is protected under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act, the Texas Medical Records Privacy Act, and/or other applicable state and federal medical privacy laws. These records cannot be disclosed without your written consent unless otherwise provided for by applicable law. Authorizing the release of information contained in your mental and medical health records constitutes waiver of a privilege. You may revoke this consent through written notice, but it will not apply to action that has been taken prior to receipt of the revocation. If not revoked earlier or noted below, this consent form expires within one calendar year upon date of completion or when you are no longer enrolled at Stephen F. Austin State University and no longer receiving services.

I, ____ , hereby request and authorize:
(print full name)

Stephen F. Austin State University- Health and Wellness Hub

2106 Raguet, Nacogdoches, Texas, 75962

PHONE: 936-462-4008 FAX: 936-468-1316

☐ To release to ☐ To receive from ☐ To discuss with

☐ Director of Sports Medicine
☐ Designated Sports Performance Coach
☐ Designated Sports Athletic Trainer
☐ Designated Athletic Academic Advisor
☐ Team Physician
☐ SFA Nursing Department
☐ Early Childhood Lab
☐ Department of Military Science- ROTC
☐ Student Outreach and Support
☐ SFA Counseling Services
☐ SFA Health Services

Other Party/Entity: ____

Phone: ______________________ Fax: ______________________

Mailing Address: ______________________ City: ____________ State: ______ Zip code: ______

The following information from the record of my care and treatment (check each category that applies):

☐ Complete psychoeducational assessment report
☐ Conversations as needed to facilitate academic support
☐ Immunizations
☐ Complete Medical Record
☐ Dates of appointments
☐ Counseling and/or psychiatric record
☐ Lab Results
☐ Office Visit
☐ Other: ____

By initialing beside the categories below, I give specific authorization to release the following information:

__________ Mental Health Records
__________ HIV/AIDs Test Results/Treatment
__________ STD Test Results/Treatment
__________ Drug, Alcohol, or Substance Abuse Records

The disclosure as authorized herein is made only for the following purpose(s):

☐ Coordination of treatment
☐ Continuation of care
☐ At my request
☐ Other: ____

Please note that the law prohibits further dissemination or use of these records for other purposes.

On this, the ________day of __________________, 20______, I have read or have had read to me, the terms and conditions of this agreement and fully understand the same. I do freely, voluntarily, and without coercion agree to those terms and the conditions contained herein.

Printed Name: ______________________________ Student ID: ______________

Student or Legal Representative Signature: ______________________________

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