STEPHEN F. AUSTIN STATE UNIVERSITY STUDENT HEALTH CLINIC
CONSENT TO RELEASE OF INFORMATION & AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, (name) ____ (CID) ________________, (DOB) _________, hereby authorize and request the disclosure of student education records and protected health information TO and FROM Stephen F. Austin State University Health Services Department and it's Student Health Clinic, P.O. Box 13058, SFA Station, Nacogdoches, Texas 75962-3058 (Fax: 936-468-1316), with/to any and all health insurance carriers (and their employees, representatives, agents, officers, and/or affiliates) that provide health insurance coverage for my treatment at the Stephen F. Austin State University Student Health Clinic and necessary university officials. The disclosure is solely for the purposes of coordinating benefits and the payment of medical claims in accordance with carrier policies and applicable law, and as necessary to conduct contact tracing and provide other related services as described herein.

I understand these records may be considered confidential 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, and I understand that by signing this authorization, I am waiving my rights of nondisclosure of this information under federal law only as to the entities specifically listed above. This release does not permit the disclosure of this information to any other persons or entities without my written consent. I also understand that this release will remain active until the conclusion of my treatment and the resolution of all pending insurance claims with the Student Health Clinic.

HIV/AIDS: I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS).

Drug/Alcohol Treatment Records: I understand that the records used and disclosed pursuant to this authorization form may include information relating to treatment and counseling for drug and/or alcohol dependency.

Mental Health Records (other than psychotherapy notes as defined under HIPAA): I understand that the records used and disclosed pursuant to this authorization form may include mental health records other than "psychotherapy notes" as that term is defined under HIPAA and is promulgating rules.

Contact Tracing/Other University Services: I understand that records and information from such records, including but not limited to COVID-19 and other contagions test results may be disclosed, solely to the extent necessary, in order to provide follow-up, wellness calls, conduct contact tracings, report absences to instructors, and activate the assistance of housing for isolation/quarantine and meal delivery.

Description of student education records and protected health information to be disclosed: all records related to my treatment at Stephen F. Austin State University Student Health Clinic, including but not limited to, a copy of my entire medical record, history form, and treatment notes.

Time Frame of Requested Information: All treatment dates at the Stephen F. Austin State University Student Health Clinic.

I understand that I may revoke this authorization in writing at any time. I understand that I may revoke this authorization by sending or faxing a written notice to the disclosing party identified above. This written revocation must state my intent to revoke this authorization. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and any revocation will not affect those actions. Furthermore, I understand that revocation will affect the ability of my health insurance carrier to pay benefits for medical treatment to Stephen F. Austin State University Student Health Clinic on my behalf.

I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand that the protected health information described above may be re-disclosed and no longer protected by federal and state privacy regulations.

Any facsimile, copy of photocopy of this authorization shall be a valid as the original.

Signature of Student or Student's Legal Representative: ______________________________________Date: _________

Printed Name of Legal Representative (if any): ____

Representative's Authority to Act for Student: ____

Witness: ____ Date: ___________