**Lubbock Christian University**
**Student Health Office** (formerly: LCU Medical Clinic)
5601 19th Street
Lubbock, Texas 79407

Telephone: (806) 720-7482
Fax line: (806) 720-7483

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

**Patient Identification:**

| Last Name | First Name | M.I. | Maiden Name (if applicable) |
|---|---|---|---|

| Date of Birth | Social Security # | LCU Student/Faculty ID # |
|---|---|---|

Are you currently enrolled at (or employed by) Lubbock Christian University? Yes ___ No ___

Dates of attendance (or employment): From _____ (Month/Year) to _____ (Month/Year)

**Types of Records/Information to be Disclosed:** (please initial appropriate lines)

_____ All records contained in my medical chart, including records from outside providers.

_____ Specified portion of my records, as noted: _____

_____

If the any of the following protected information needs to be included, please authorize by initialing below:
_____ alcohol or substance abuse and treatments
_____ HIV test results / AIDS diagnosis
_____ psychiatric/mental health diagnosis or treatment by a mental health provider

**Purpose of Releasing Information:** _____

**Facility Authorized to SEND information:**

Name: LCU Medical Clinic / Student Health Office

Address: 5601 19th Street

Lubbock, Texas 79407

Phone: (806) 720-7482 Fax: (806) 720-7483

**Facility/Person Authorized to RECEIVE Information:**

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

**Expiration of Authorization:** This authorization will expire on _____ (date -- not to exceed one year). If left blank, authorization will expire 90 days from date of signature below.

**Authorizing signature**

- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date