Authorization for Release of and/or Verbal Exchange of Confidential Medical Information

I authorize Student Health and Counseling Services to:

( ) Send a copy of my specific medical information to the person or entity below.

( ) Verbally exchange specific medical information with the person or entity named below.

RELEASE TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

AND/OR

(Please initial each request)

	Office of Academic Records
	Office of Disability Services
	Office of Financial Aid & Scholarships
	Office of Student Conduct
	Care Team
	Other:

You must INITIAL each selection requested and provide Date(s) of Service

Initials	Record	Date(s)of Service
	Office Visit	
	Most Recent Pap	
	Date of Last Depo-Provera	
	Lab Reports	
	X-Ray Reports	
	Immunization(s)	
	TB Skin Test	
	Medication Summary	

Initials	Record	Date(s) of Service
	Counseling History	
	Counseling Intake Assessment	
	Counseling Dates of Treatment	
	Counseling Diagnosis	
	Counseling Treatment Summary	
	Drug/Alcohol Information	
	Letter for Academic, Financial, or Disability Consideration	

REASON FOR REQUEST					
	Continuity of Care (follow-up)		Consultation		Academic/Financial/Disability Services
	Transferring		Personal		

I fully understand that my medical record for the above date may contain psychiatric/developmental disability, alcohol/drug abuse, and/or Acquired Immune Deficiency Syndrome/HIV test results and/or information.

This Authorization of Release pertains only to the above-specified information and to the above-specified parties. I understand that I may revoke this authorization at any time in writing and the authorization will remain valid until revoked or upon expiration of one year from the date of this signed release.

I understand that this information, once disclosed, may be re-disclosed outside the privacy rule.

I understand that I have the right to refuse to sign this form, and my refusal will not result in the ability or inability to condition treatment, payment, enrollment, or eligibility for benefits.

I absolve Student Health and Counseling Services and its agents, trustees, officers, and employees from any legal liability, which may arise from the disclosure of this information.

Name (Print): _____ Date needed by: _____

UTM Student ID: _____ Date of Birth: _____

Phone: _____ **Circle Choice: PICK UP MAIL**

Signature: _____ Date: _____

STUDENT HEALTH AND COUNSELING SERVICES

University of Tennessee at Martin, 609 Lee Street, Martin, TN 38238 **T** 731.881.7750 **F** 731.881.7752 http://www.utm.edu/departments/shcs/

(Revised 01/03/19)