DIVISION OF STUDENT ENGAGEMENT
LAMAR UNIVERSITY
Student Health Center
Medical and Counseling Services

Authorization for Disclosure of Protected Health Information

Individual: _____ Date of Birth: _____ LU/LIT ID#:_____

Description of information to be released: _____

_____.

Your initials are required to release any the following protected health information:

___Mental Health Records; excluding psychotherapy notes; ___Drug, Alcohol & Substance Use Records; ___HIV/AIDS

I authorize the following facility to disclose my protected health information:

Person/Organization Name: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

Receiving entity of my protected health information:

Name: Lamar University Student Health Center
Address: 857 East Virginia Street, Beaumont, Texas 77705
Phone: (409) 880-8466
Secure Fax: (409) 880-7703

Method of Transmission – (Check your preference): □ Pick Up □ Fax □ Postal Mail

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Effective Time Period: This authorization expires on _____. (Maximum of six months).

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Lamar University Student Health Center. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Cod 181.154© and/or 45 C.F.R. 164.502 (a)(1).

Signature X_____ _____
Signature of Individual or Individual's Legally Authorized Representative Date