**PATIENT INFORMATION**

TTUHSC MRN:_____

PATIENT NAME: _____ DATE OF BIRTH:_____

Address:_____ Day Phone:_____

City:_____ State:_____ Zip:_____

**RECEIVING PARTY**

NAME:_____Laboratory reports

**Send** the information to:

**Receive** the information from:

Other (pl 3. Mental health information Yes___

4. Genetic testing Yes___ No___

**RELEASE INSTRUCTIONS** (**How** do you want the information?)

Electronic Form (CD/USB preferred method) Paper

**PURPOSE OF RELEASE**

(Why is it needed?)

Continuing Care by other health care provider
Disability School

- This authorization is voluntary and I may ref use to sign it. My treatment or payment for services will not be affected if I do not sign this Authorization.
- This Authorization may be canceled by submitting a written notice to Texas Tech University Health Sciences Center (or the releasing facility). I nformation may be released until my written notice of cancellation is received.
- **This Authorization expires 180 days from the date signed or on the following date or event (specify)** _____
- Additional information is in TTUHSC's Notice of Privacy Practi ce.
- If the healthcare services are being provided at the request of and being paid for by my employer (or prospective employer), I understand and agree that all records and information related to the healthcare services provided to me may be given directly to my employer and if I wish to obtain such information, I must contact my employer/prospective employer.

**RELEASE FROM LIABILITY:** I release and agree to hold harmless TTUHSC Clinic (or other releasing facility) and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with the Authorization. I understand TTUHSC Clinic (or the releasing facility) cannot be responsible for use or rediscover of information to third parties.

_____ _____ _____
Patient or Legally Authorized Signature

_____ _____ _____
Time Witness/Translator * Relationship to patient