TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

TTUHSC Medical Records Office – Odessa
701 W. 5th Street, Room 1243
Odessa, Texas 79763
Phone: 432-703-5440
Fax: 432-335-1480
Email: Permianbasinmedicalrecords@ttuhsc.edu

HIPAA Authorization to Release Medical Records – Odessa

Part 1. Patient Information			MRN:
Name:	Date of Birth:	Phone:	Email Address:
Street Address:	City:	State:	Zip Code:

Part 2. Receiving Party Information (Check one appropriate box)

☐ **Give me a copy of my medical records** ☑ **Send the records to:** TTUHSC ☑ **Receive the records from:** MPA

Name: TTUHSC	Fax:	Phone:	Email Address:
Street Address: 4214 Mamies Circle	City: Midland	State: Tx	Zip Code: 79707

Part 3. Information to Be Released (What do you want sent or released? Check one appropriate box.)

☑ All Medical Records ☐ Medical Records from _____(Date) to _____(Date)

☐ Other (Please specify):

I understand that information in my health record may include information relating to: (1) AIDS/HIV test results, infection status, or treatment information; (2) Substance Use Disorder (SUD) Records, including drug and alcohol abuse records; (4) behavioral and mental health records; (5) Genetic Information.

I authorize the disclosure of this information except as follows:

Part 4. Release Instructions (How do you want the information?)

☐ Paper Copy for In-Person Pick Up ☐ Mail ☐ Fax ☐ Email (Encrypted) ☐ Email (Unencrypted)* ☑ Other

*If you request your medical record to be sent to you unencrypted via your personal email, you acknowledge and accept the risk that your PHI is being transmitted through an unsecure means of communication.

Part 5. Purpose of Release (Why is it needed?)

☐ At the Request of the Individual ☐ Attorney/Legal ☐ Disability Determination ☐ Insurance

☐ Continuing Care by Other Provider ☐ Personal Review ☐ School ☑ Other: MERGE

Part 6. Notice To the Receiving Party: Medical records may include Substance Use Disorder (SUD) patient records. 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.

Part 7. Signature Authorization

By signing below, I understand the following:

- I hereby authorize Texas Tech University Health Sciences Center (TTUHSC) to disclose my protected health information (PHI). A valid government-issued photo ID will be required for patient privacy and confidentiality purposes. I understand a processing and shipping fee may apply.
- This authorization is voluntary, and I may refuse to sign it. TTUHSC will not condition treatment, payment, enrollment, or eligibility for benefits based on the completion of this form.
- I understand that to the extent that any recipient of this information, as identified above, is not a "covered entity" under the Federal or Texas privacy laws, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient, and, therefore, may be subject to re-disclosure by the recipient.
- This Authorization may be revoked by submitting a written notice to the TTUHSC Compliance Office (or the releasing facility). Information may be released until the written notice of revocation is received. Unless otherwise revoked, I understand that the date or event upon which this authorization expires is 180 days from the date of signature.
- 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, and 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 the use or disclosure of information to third parties.

Patient's Name:	Patient's Signature:	Date:
Legal Representative's Name**:	Legal Representative's Signature:	Date:

**If legal representative, please specify relationship to patient. You MUST attach proof of your authority to act on behalf of the patient (other than the parent).