

Texas Tech University Health Sciences Center Patient Request for Access of Health Information	Patient Name: _____ MRN: _____ DOB: _____
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If you would like a copy of your medical record, please complete the form below.

Patient Name: _____ Date of Birth: _____
Street Address: _____ Last 4 numbers of SSN: _____
City, State, Zip: _____ Telephone: _____
Email address: _____

I would like for Texas Tech University Health Sciences Center (TTUHSC) to (choose one):

- Give me a copy of my health information
 Send my records to: Receive the information from:

(Name of Facility, Person, Company) (Street address or PO Box, City, State, Zip Code)
(Phone Number) (Fax Number)
(Email Address)

I would like these dates of service to be released: _____

Information to be released:

Any and All records (complete record)
Only record types checked below:
 Progress Notes/clinic notes Schedule
 Laboratory Reports Other (please specify) _____
 Immunization Record Billing Records (dates) _____
 Medication Record Routine Record Set (Indicate date(s) of service _____
(office visits, lab, radiology, medicines, immunizations)
I agree that the following information may be released/used only as indicated below:
1. Aids/HIV test results, diagnosis, treatment, and related information Yes ___ No ___
2. Drug screen results and information about drug and alcohol use and treatment Yes ___ No ___
3. Mental health information Yes ___ No ___
4. Generic testing Yes ___ No ___

I want these records as a (chose one):

- CD-encrypted – password _____ CD-unencrypted
 USB –encrypted – password _____ USB-unencrypted
 Electronic
 Paper copy
 Other: _____

I want you to (choose one):

- Mail them
 Send via email (encrypted)
 Send via email (unencrypted)
 Fax them to: _____
 Prepare them to be picked up by _____

If you request your medical record to be sent to you unencrypted via your personal mail, you acknowledge that your PHI is being transmitted through an unsecure means of communication.

Signature: _____ Print Name: _____

Relationship to Patient: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this document for the patient (Written Proof may be required)

To be completed by TTUHSC:

Date of release: _____ via Mail Fax Other _____
 ID Verified DL/Other ID _____
Employee Name: _____ Date: _____