

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: _____

(Please initial each request)

☐	Office of Academic Records
☐	The Accessibility and Resource Center
☐	Office of Financial Aid & Scholarships
☐	Office of Student Conduct and Care
☐	Other: _____

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

Initials	Record	Date(s) of Service	Initials	Record	Date(s) of Service
	Office Visit			Counseling History	
	Most Recent Pap			Counseling Intake Assessment	
	Date of Last Depo-Provera			Counseling Dates of Treatment	
	Lab Reports			Counseling Diagnosis	
	TB Skin Test			Counseling Treatment Summary	
	Medication Summary			Drug/Alcohol Information	
	STI Results Including HIV/Hepatitis			Letter for Academic, Financial, or Disability Consideration	
	Other:			Other:	

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

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/>