DBU
DALLAS BAPTIST UNIVERSITY

CONSENT/AUTHORIZATION TO ACCESS OR RELEASE PROTECTED HEALTH INFORMATION

Last Name (Please Print) First Name Middle Maiden Name

Date of Birth DBU ID# Last 4 Digits of Social Security #

Are you currently enrolled in classes at DBU? □ Yes □ No If no, give semester and year that you last attended _____

PLEASE NOTE: For health records requested from DBU Health Services, the medical records will be copied. All records from outside providers will be excluded.

□ I request that Dallas Baptist University Health Services release my records to the following person/facility:
□ I give permission to Dallas Baptist University Health Services to discuss my medical care with the person below:
□ I request that the facility below release my records to Dallas Baptist University.
□ I give my permission for Dallas Baptist University Health Services to use an outside service to translate my health records.
□ I give my permission for Dallas Baptist University Health Services to obtain and use my records to comply with the Bloodborne Pathogens Exposure Control Plan.

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Fax: _____ Phone: _____

CHECK ALL BOXES THAT APPLY

□ All Medical Records □ Immunization Record(s)

1. ***I am aware and understand that the information to be released may include information and documents considered to be confidential and sensitive. I give my specific authorization to release the selected health care information containing such material.***
2. I am aware that once the above records are released, Dallas Baptist University and Dallas Baptist University Health Services will no longer be responsible for the security of the disclosed information.
3. I understand authorizing the use or disclosure of the information selected above is voluntary.
4. A copy of these health records may be utilized with the same effectiveness as an original.
5. I understand that I may withdraw my permission at any time by notifying Dallas Baptist University Health Services in writing.

I have read and acknowledge that I understand the terms and conditions of this request. I release both facilities from any liability complying with this request.

Signature of Patient or Representative (include relationship to patient) Date

Signature of Staff/Witness Date

3000 Mountain Creek Parkway | Dallas, Texas 75211-9299
214.333.7100 | www.dbu.edu