Texas Academy of Mathematics and Science
PO Box 305309
Denton, TX 76203

Request for Release of Medical Records

I, ____ ____________________
(Print Name) (SS#)

Do authorize the TAMS Student Life Office to release (circle one of the following) partial / complete copies of my medical records including reports, opinions, evaluations, and any of the information which pertains to the medical care I received at their facility.

AIDS/HIV Infection information is within the scope of this release, unless exception is noted: N/A.

Alcohol and Drug Use information and/or treatment for Alcohol or Drug Use is within the scope of this release, unless exception is noted: N/A.

Mental Health information is within the scope of this release, unless exception is Noted: N/A.

If **partial** was circled, then identify the specific records to be released:
Immunizations.

Reason/purpose for release: (Please circle or identify) Personal Records / Specialist
Other: ________________________________

Please release records to the following address:

____
Name of self/Specialist/Other

____
Street Address or PO Box Number

____
City State Zip Code

The above authorization to be in effect until such time as I revoke it in writing. An original authorization, or photocopy hereof, will authorize you to release all of the information requested above.

Signature of Patient ________________________________ Date ____________

Failure to provide all of the required information for release of medical records will result in the form being returned to you for completion.

***(Bottom Portion for use of Medical Records Office)**

Date given/sent: ____________

Approval to release Medical Records: ________________________________