Midwestern State University (MSU) - Member, Texas Tech University System
3410 Taft Blvd., Wichita Falls, Texas 76308
940-397-4231; fax 940-397-4504

MSU Vinson Health Center **Patient Request for Access of Health Information**	Patient Name: _____ MRN: _____ DOB: _____

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 MSU Vinson Health Center to (choose one):
☐ Give me a copy of my health information ☐ received from:
☐ Send my records to:

_____
(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: _____

I want these parts of my record:

☐ 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. Genetic testing Yes ____ No ____

I want these records as a (chose one):
☐ CD
☐ Electronic
☐ Paper copy
☐ Other: _____

I want you to (choose one):
☐ Mail them
☐ Send them secure email
☐ Send them personal email (unsecure)
☐ 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 email, you acknowledge and accept the risk 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 MSU:
Date of release: _____ via Mail Fax Other_____
ID Verified DL/Other ID_____
Employee Name: _____ Date: _____