



Individual: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ LU/LIT ID#: \_\_\_\_\_

Description of information to be released: \_\_\_\_\_

\_\_\_Mental Health Records; excluding psychotherapy notes; \_\_\_Drug, Alcohol & Substance Use Records; \_\_\_HIV/AIDS

Person/Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Name: Lamar University Student Health Center  
Address: 857 East Virginia Street, Beaumont, Texas 77705  
Phone: (409) 880-8466  
Secure Fax: (409) 880-7703

**Method of Transmission – (Check your preference):**    ☐ Pick Up    ☐ Fax    ☐ Postal Mail

**Effective Time Period:** This authorization expires on \_\_\_\_\_. (Maximum of six months).

**Right to Revoke:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Lamar University Student Health Center. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**Signature Authorization:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Cod 181.154© and/or 45 C.F.R. 164.502 (a)(1).

**Signature X** \_\_\_\_\_  
Signature of Individual or Individual's Legally Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_



DIVISION OF STUDENT AFFAIRS  
**LAMAR UNIVERSITY**  
Student Health Center

**Signature X**

\_\_\_\_\_  
Signature of Individual or Individual's Legally Authorized Representative

\_\_\_\_\_  
Date