Student Health and Wellness
Counseling Services
700 University BLVD., MCS 112 (Mailing)
1210 N. Retama Street (Physical)
Kingsville, Texas 78363-8202
Phone: (361) 593-5080 * Fax (361) 593-2006

Counseling Records Request and Authorization

Date:_____

Attach a copy of your photo ID and send it to the TAMUK Counseling Services via fax, secure email, mail, or in-person drop-off.

Requestor type (check one)

☐ Patient/self
☐ Legal representative (attach POA, court order, or other authority)
☐ Parent/guardian of minor (attach proof)

Student Information

First Name: _____Middle Name: _____Last Name_____

Date of Birth _____ E-Mail Address_____

(TAMUK Students) K # _____ (College of Pharmacy Students) *Last four #'s of UIN* _____

Mobile Number (_____) _____-_____ Home Number (_____) _____-_____

Local Address_____
(Where you live while attending college) (Street) (City) (State) (Zip)

Permanent Address_____
(Where you live while not attending college) (Street) (City) (State) (Zip)

Contact you by: (check all that apply) ☐ Phone ☐ E-Mail ☐ Local Address ☐ Permanent Address

Records requested (check all that apply and specify dates)

☐ Date range: From _____ To _____
☐ Intake/diagnostic assessments
☐ Treatment plans/goals
☐ Progress notes (excluding separate psychotherapy notes)
☐ Discharge/termination summary
☐ Medication list and referrals
☐ Test results and outside records received
☐ Other (specify):

Delivery preference

☐ Electronic PDF via secure email/portal (provide email/portal account): _____

☐ Paper copies by mail (provide address): _____

☐ Pick up in person (ID required): _____

I consent to include the checked categories above:

Initial here: _____

Sensitive information consent (optional; check to include, if applicable)

☐ Mental/behavioral health information

☐ Substance use disorder treatment information

☐ HIV/STD testing or treatment information

☐ Reproductive health information

I consent to include the checked categories above:

Initial here: _____

Fees and timing

I understand reasonable, cost-based fees for copying, mailing, or preparing electronic files may apply.

Initial here: _____

Identity verification

☐ I have attached a copy of my government-issued photo ID.

☐ If I am a representative, I have attached documentation of my authority.

☐ This authorization expires on (date _____ or 180 days from signature): Initial here: _____

☐ I may revoke this authorization in writing at any time, except to the extent it has already been relied upon.

Acknowledgment of redisclosure risk

I understand that once records are disclosed to a third party, they may be subject to redisclosure and may no longer be protected by HIPAA (except for specially protected records like certain substance use disorder treatment records).

Signature: _____

Signature of patient or authorized representative: _____

Printed name: _____

Relationship to patient (if not patient): _____

Date: _____

This request is made pursuant to HIPAA (45 C.F.R. § 164.524), the Texas Medical Records Privacy Act (Texas Health & Safety Code Chapter 181), and Texas Mental Health Records law (Texas Health & Safety Code Chapter 611). If any portion cannot be disclosed, a written explanation citing the specific legal basis, and, if applicable under Chapter 611, a summary or release to another qualified professional may be provided.