Authorization for Release of Medical Records

THE UNIVERSITY OF TEXAS AT AUSTIN
DIVISION OF STUDENT AFFAIRS
UNIVERSITY HEALTH SERVICES
healthyhorns.utexas.edu

I authorize the following protected health information to be released from the medical record of:

LAST NAME (PLEASE PRINT) _____ FIRST NAME (PLEASE PRINT) _____ DATE OF BIRTH _____

EMAIL ADDRESS _____ UTEID _____ TODAY'S DATE _____

PHONE NUMBER _____

Release Records
- ❑ **From**
- ❑ **To**

University Health Services
H.I.M. - Records Release
P.O. Box 7339
Austin, TX 78713-7339
Fax 512-475-8282
Phone 512-475-8226

Release Records
- ❑ **To**
- ❑ **From**

NAME/ORGANIZATION _____
ADDRESS _____
CITY _____ STATE ZIP CODE _____
PHONE _____ FAX _____

❑ **Please mail my records** ❑ **Please call when my records are ready for pick-up** ❑ **Please fax my records**

➡ NOTE: Fee schedule available at healthyhorns.utexas.edu/records

I understand that to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

TO BE RELEASED	DATE OF SERVICE / PROVIDER	TO BE RELEASED	DATE OF SERVICE / PROVIDER
❑ Office visits and lab	_____	❑ Immunizations	_____
❑ Gyn visits and lab	_____	❑ Physical therapy notes	_____
❑ Urgent Care visits	_____	❑ Nurse Advice Line	_____
❑ Lab work	_____	❑ Entire record	_____
❑ Radiology reports	_____	❑ Other	_____

➡ NOTE: If specific dates to be released or a specific provider are not indicated, all records in the category marked will be released.

REASON FOR RELEASE OF INFORMATION
- ❑ At the request of the individual.
- ❑ Other (DESCRIBE REASON FOR DISCLOSURE) _____

I understand that this authorization is valid for six months unless I notify UHS otherwise. I may revoke this authorization in writing at any time except to the extent that UHS has already relied on this authorization. I may revoke it by mailing or faxing a written notice to the H.I.M. Administrator to the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. I will be billed per the posted fee schedule. The information will be provided to me within 21 days of my request.

➡ NOTE: If mailing or faxing this form, please include a copy of your photo ID.

SIGNATURE OF PATIENT (OR IF LEGAL REPRESENTATIVE-STATE AUTHORITY TO ACT) _____ DATE _____

I have verified the patient's identification and notified him/her of the fee.

UHS STAFF SIGNATURE / DEPARTMENT _____ DATE _____

UHS STAFF ONLY

Date Released: _____ Released by: _____

Notes _____