



healthyhorns

University Health Services

Authorization for Release of Medical Records

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
 ATTN: Records Release
 100 West Dean Keeton St. STOP A3900
 Austin, TX 78712-1107
 Phone 512-475-8226
 Fax 512-475-8282
 Alt. Fax 833-285-1616

Release Records

- To
- From

NAME/ORGANIZATION
 ADDRESS
 CITY STATE ZIP CODE
 PHONE FAX

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

➔ NOTE: Search "medical records" at healthyhorns.utexas.edu for forms, fees, and other information about your records at UHS.

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

- Office visits and lab
- Gyn visits and lab
- Urgent Care visits
- Lab work
- Radiology reports

TO BE RELEASED

DATE OF SERVICE / PROVIDER

- Immunizations
- Physical therapy notes
- Nurse Advice Line
- Entire record
- 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.
- Medication refill:

NAME OF MEDICATION
 START DATE OF MEDICATION

NAME OF PRESCRIBING PROVIDER
 LAST REFILL DATE

- 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 15 days of my request.

➔ NOTE: If mailing or faxing this form, please include a copy of your photo ID. This authorization must be physically signed. UT does not recognize E signatures as a valid signature for medical record releases.

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: _____