Authorization for Release of Medical Records

The University of Texas at Austin
University Health Services
Division of Student Affairs

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
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	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.

☐ Medication refill: _____ _____
NAME OF MEDICATION NAME OF PRESCRIBING PROVIDER

_____ _____
START DATE OF MEDICATION 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: _____