UT ★ Physicians

(For UTP patients to request UTP to send medical records to self, other provider, or outside entity)

# AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **I hereby authorize UT Physicians to use and disclose protected health information from the record(s) of:**

Patient's Name (Print): ______________________________ Birth date: _______________ or MRN: ________________

Phone #: ____________________________

2. **Copies of the following records shall be used and disclosed:**

☐ Complete Clinical Records (if requesting **genetic** or **psychotherapy**, please specify); and/or

☐ Other (specifically identify exact information to be disclosed, ***including dates of service***)

| | | |
|---|---|---|
| ☐ History and physical exam: | ☐ Laboratory test reports: | ☐ Photographs, videos, etc.: |
| ☐ Consultation reports: | ☐ Discharge Summary: | ☐ Physical Therapy Notes: |
| ☐ X-ray reports: | ☐ Progress Notes: | ☐ Other: |

Other:_____________________________________________________________________________________________

_____________________________________________________________________________________________________

3. **I understand that the records used and disclosed pursuant to this authorization form 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.**
4. **I understand that copies of the records indicated above will be: (check one or more, as applicable)**

☐ Sent to or Make Available to: ________________________________________________
(Name of Recipient)

________________________________________________
(Name of Company)

________________________________________________
(Address, City, State, Zip Code)

☐ Faxed to: ________________________________________________
(Name of Recipient)

________________________________________________
(Name of Company)

*Professional Offices Only* ________________________________________________
(Fax Number) (Confirmation Telephone Number)

5. **I understand there may be a fee assessed for these records.**
6. **I understand that to the extent 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.**
7. **I understand that the purpose(s) of the requested use and disclosure is (are):** ______________________________

_____________________________________________________________________________________________________

8. **I understand that I may revoke this authorization in writing at any time except to the extent that UT Physicians has already relied on this authorization. I understand that I may revoke this authorization by faxing a written notice to 713-512-2252.**
9. **Unless otherwise revoked, this authorization will expire on the 180th day of the signing or as otherwise specified:**

_____________________________________________________________________________________________________

10. **I understand that UT Physicians may not condition treatment on the completion of this authorization form.**

**Signature of Patient or Patient's Legal Representative:** ________________________________ **Date:** _______________

**Printed Name of Legal Representative (if any):**__________________________________________________________

**Representative's Authority to Act for Patient:** __________________________________________________________

***Include copy of legal documents**