UT Physicians

(To request medical records from another provider)

UNIVERSAL AUTHORIZATION
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I hereby authorize, _____
(Name of physician, health care facility)

_____
(Address: city, state, zip)

_____
(Telephone number, fax number)

to use and disclose protected health information from the record(s) of:

Patient's Name (Print): _____ Birth date: _____

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

☐ Complete Clinical Records; 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: Medical Records
(Name of Recipient)

UT Physicians
(Name of Company)

_____
(Address, City, State, Zip Code)

☐ Fax to: 713-512-2250 (Fax Number) 832-325-6543 (Confirmation Telephone Number)

5. 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.

6. I understand that the purpose(s) of the requested use and disclosure is (are): _____

_____

7. I understand that I may revoke this authorization in writing at any time except to the extent that, _____ **(name of physician, facility) has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to** _____ **(name of physician, facility, etc. & address)**

8. Unless otherwise revoked, this authorization will expire on the 180th day of the signing or as otherwise specified below: _____

9. I understand that _____ **(name of physician, facility) may not condition treatment on my 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: _____