The University of Texas at Austin
UT Health Austin

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Information

Name: _____ Date of birth: _____

Other names used: _____ Phone: _____

Address: _____

_____

I authorize UT Health Austin to use and disclose protected health information (PHI) from the medical record(s) of the patient above. The following person or party may receive the PHI:

Name: _____ Phone: _____

Address: _____

_____

I ask that the following be given to the person or party above: (select any items you want UT Health Austin to send*)

- ❑ *All medical records*
- ❑ History & Physical
- ❑ Discharge Summary
- ❑ Billing Information
- ❑ Past/Present Medications
- ❑ Diagnostic Test Reports
- ❑ Radiology Reports & Images
- ❑ Lab Results
- ❑ EKG/Cardiology Reports
- ❑ Other: _____

*The signature of a minor patient may be required for the release of some of these items.

UNLESS YOU INITIAL HERE, no information about mental health, alcohol/substance abuse, HIV/AIDS test results, or genetic information will be disclosed. YES, PLEASE DISCLOSE:

_____ Genetic Information

_____ Drug, Alcohol, or Substance Abuse Records

_____ HIV/AIDS Test Results/Treatment

_____ Mental Health Records (excluding psychotherapy notes)*

*Release of psychotherapy notes requires a separate Authorization

Reason for Disclosure (select one):

- ❑ Treatment/ Continuing Medical Care
- ❑ At the Request of Patient
- ❑ Other _____

This authorization will last for one year or until _____ (date or event).

By signing below, I agree:

- *I have read this form and agree UT Health Austin may release my information as set forth above. I may withdraw my permission at any time. If I withdraw my permission, my PHI will not be released again as set forth above. However, any disclosures already made based on this will not be affected. I may withdraw my permission by notifying UT Health Austin in writing.*
- *UT Health Austin will not require me to sign this form to be treated. I may request a copy of this signed form.*
- *I understand PHI disclosed pursuant to this Authorization may be subject to re-disclosure by the person or party it goes to and may no longer be protected by federal or state privacy laws.*

Signature of Patient or Representative: _____ ***Date:*** _____

Printed Name of Patient or Representative: _____ ***Relationship to Patient:*** _____