



UT★PHYSICIANS

HIM Dept., 6410 Fannin, LL100, Houston, Texas 77030, 832-325-6543

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (FOR UTP PATIENTS TO REQUEST UTP TO SEND MEDICAL RECORDS TO ANOTHER PROVIDER)

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 Social Security Number: _____

2. Copies of the following records shall be used and disclosed:
____ Complete Clinical Records; 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 _____

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: Name of Recipient: _____
 Name of Company: _____
 Address: _____
 City _____ State: _____ Zip Code: _____

____ Faxed to: Name of Recipient: _____
 Name of Company: _____
 Fax Number: _____
 Confirmation Telephone Number: _____

____ Made available to: Name of Recipient: _____
 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 UT Physicians has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to 6410 Fannin, Suite LL 100 Houston, Texas 77030, 713-512-2252 fax.

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

9. I understand that UT Physicians 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: _____