UNIVERSAL AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
(To request medical records from another provider)

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: _____ 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 Immunoeficiency 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 _____(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: _____
[UT Physicians Medical Records Telephone: 832-325-6543, Fax: 713-512-2250]