

**Medical Records, 6410 Fannin, LL135, Houston, TX 77030, Ph. 832-325-6543 Fax 713-512-2252**

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

- 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 number: \_\_\_\_\_
- Copies of the following records shall be used and disclosed:  
 \_\_\_\_\_ Complete Clinical Records; (if requesting **genetic** or **psychotherapy**, please specify.)  
 \_\_\_\_\_ Provider \_\_\_\_\_  
 \_\_\_\_\_ 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 _____	Psychotherapy _____
EKG, Echocardiogram _____	Genetics _____	Other _____

- 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.
- I understand that copies of the records indicated above will be: (check one or more, as applicable)

**Send To** Recipient Name: \_\_\_\_\_  
 Company Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, and Zip Code: \_\_\_\_\_

**Fax To** Recipient Name: \_\_\_\_\_  
 Company Name: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**EHI** Delivery Method:  MyChart  Other (Fees apply)

\*\*The Electronic Health Information (EHI) option contains the COMPLETE record including HCPC records. It is **not human readable** and requires special computer applications to translate the data. This disclosure type will only be disclosed to patients.

- I understand there may be a fee assessed for these records.
- 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.
- 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 sending or faxing a written notice to 6410 Fannin, Suite LL 100 Houston, Texas 77030, 713-512-2252 fax.

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

- 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: \_\_\_\_\_ (Include copy of legal documents)