UT Health San Antonio
The University of Texas Health Science Center at San Antonio

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Authorization for Release of Health Records to External Parties

1. I authorize **UTHSCSA *(The University of Texas Health Science Center at San Antonio)*** to disclose information from the health records of:

   Patient Name:_____ Date of Birth: _____

   Phone:_____ SSN (last 4 digits): _____ Medical Record # (if known):_____

2. **The information is to be disclosed to:**

   Name of Person or Organization: _____

   Address:_____ City, State, Zip:_____

   Fax:_____ Phone: _____

3. **Purpose of the disclosure:** _____

4. I authorize this information to be disclosed in the following ways:

   ❑ Paper (Mailed) ❑ Fax ❑ MyChart ❑ Pick up ❑ Electronic Mail (requires a signed Email Authorization Agreement)

5. **REQUIRED: Dates Requested** From:_____ To:_____ ***or*** ❑ Most Recent (last 3 visits)

   Physician / Clinic Name: _____

   Specific reports to be disclosed:

   ❑ Progress / Visit Notes ❑ Diagnostic Reports ❑ Biopsy / Pathology Reports
   ❑ Laboratory Reports ❑ Consultation Reports ❑ Photographs / Video
   ❑ Radiology Reports ❑ Procedure Reports ❑ Immunization Records
   ❑ Other (specify):_____

   ❑ **Radiology Images on CD (specify study and date)** _____

6. I give specific authorization to disclose the following information:

   ❑ HIV Test Results ❑ Drug and alcohol abuse treatment records ❑ Genetic information / testing
   ❑ Documentation of AIDS diagnosis ❑ Psychiatric / Behavioral / Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying UTHSCSA in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization **expires in one year** unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____

Signature of Patient (or Legal Representative*) Date

_____ _____

Printed Name of Patient (or Legal Representative*) Authority of legal representative to act for patient*

**Legal representative must submit a copy of legal documents supporting authority to act on patient's behalf.*