University Health
Detention Health Care Services
200 N. Comal, Suite MT01
San Antonio, Texas 78207
Phone Number: (210) 335-6260 Fax: (210) 335-6193

Authorization To Use And Disclose Protected Health Information

Patients Name: _____ SID No: _____
Last First Middle

Social Security Number: _____- _____ - _____ Date of Birth: _____

Home Address: _____
Street City State Zip Code

In the event of medical emergency or a medical determination that you lack medical decision making capacity, please contact:

Name: _____ Relationship: _____ Telephone Number:_____

Home Address: _____
Street City State Zip Code

Alternate Contact:

Name: _____ Relationship: _____ Telephone Number: _____

Home Address: _____
Street City State Zip Code

FOR PURPOSES OF YOUR HEALTH AND SAFETY, THE ADMINISTRATION AND MAINTENANCE OF THE SAFETY, SECURITY, AND GOOD ORDER OF THE CORRECTIONAL INSTITUTION, AND COORDINATION OF SOCIAL AND MEDICAL SERVICES, DURING INCARCERATION IN THE BEXAR COUNTY ADULT DETENTION CENTER, I HEREBY AUTHORIZE UNIVERSITY HEALTH (UH) **DETENTION HEALTH CARE SERVICES** TO DISCLOSE PROTECTED HEALTH INFORMATION (AS IDENTIFIED BELOW) TO THE **BEXAR COUNTY SHERIFF'S OFFICE**. THIS AUTHORIZATION COVERS ANY TREATMENT RECEIVED OR INFORMATION OBTAINED DURING MY INCARCERATION AND MAY INCLUDE RECORDS OF TREATMENT PROVIDED AT OTHER UHS FACILITIES.

Description of Items to be released: (Check all that apply)

☐ **Entire Health Care Record During Incarceration**	☐ **Consultation Reports**	☐ **Financial Information: Income/Benefits**
☐**Mental Health Diagnosis/ Treatment/ Prognosis**	☐ **Laboratory Reports**	☐ **Discharge Summary**
☐ **Alcohol/Drug Abuse History/ Treatment/Prognosis**	☐ **Operative Reports**	☐ **History and Physical**
☐ **Emergency Center/ University Hospital Treatment**	☐ **Pathology Reports**	☐ **HIV-Related Information**
☐ **Physician Orders**	☐ **Radiology Reports**	☐ **Sick Call Requests**
☐ **Physician Progress Notes**	☐ **Nursing Notes**	☐ **Medication Administration Summary**

The above information will be disclosed to the Bexar County Sheriff's Office upon request. All requests for information authorized by this form will be facilitated through UH Medical Records Department, in coordination with the UH Detention Health Care Services, in accordance with its policies and procedures.

- I understand this authorization will not expire until I am released from custody.
- I understand that information released to the Bexar County Sheriff's Office may no longer be protected by federal and state privacy regulations.
- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to University Health Detention Health Care Services. I understand the revocation will not apply to information that has already been released as authorized by this document.
- I understand this authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment and that my health care will not be affected if I do not sign this form.
- I understand the information in my health records may include information relating to AIDS, HIV, psychiatric, behavioral or mental health services, and chemical or alcohol dependency. This authorization does not include psychotherapy notes.
- I understand that this authorization or its revocation will have no impact on the Bexar County Sheriff Office obtaining my protected health information as allowed by the Custodial or Law Enforcement exceptions to HIPAA.

_____ _____
Patient's Signature **Date** **Witness' Signature** **Date**

SUBMIT