



4502 Medical Drive  
 Medical Records Department, MS# 26-2  
 San Antonio, Texas 78229-4493

Phone (210) 358-3532

Fax (210) 358-5936

**Authorization for Release of Behavioral Health Records**

I, \_\_\_\_\_, hereby authorize University Health to release to:

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip Code

Patient's Name: \_\_\_\_\_

Last First Middle

Address: \_\_\_\_\_

Street City State Zip Code

Phone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MRN: \_\_\_\_\_

Information is to be limited to the following **Dates of Treatment** (if applicable): \_\_\_\_\_

Information requested to be released:  Behavioral Health Record (may include, any and all mental health, psychotherapy records)  
*(If other types of documents are to be released, use BCHD# 282, Authorization to Access, Inspect and/or Obtain a Copy of Health*

Purpose of access or release:  Medical Care  Insurance or Other Payment  Patient Request

Other (explain): \_\_\_\_\_

I understand this authorization will expire on (Date) \_\_\_\_\_ or 180 days from the date of this signed authorization.

I understand if the recipient authorized to receive the information is not a health plan or health care provider, the released information 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 the Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization.

I understand authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

University Health, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
 Patient Signature Date

\_\_\_\_\_  
 Signature of Other Person Legally Authorized Relationship to Patient Date  
 To Sign Authorization on Behalf of Patient

**FOR University Health USE ONLY** DATE RECEIVED \_\_\_\_\_

APPROVED \_\_\_\_\_ DENIED \_\_\_\_\_ (WRITTEN STATEMENT OF DENIAL FROM PROVIDER REQUIRED. MUST ATTACH FORM BC #224)

PRINT Name/Title: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

