University Health
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 To Sign Authorization on Behalf of Patient | Relationship to Patient | Date

FOR UNIVERSITY HEALTH SYSTEM USE ONLY **DATE RECEIVED_____**

APPROVED_____ DENIED_____ (WRITTEN STATEMENT OF DENIAL FROM PROVIDER REQUIRED. MUST ATTACH FORM BC #224))

PRINT Name/Title: _____ Provider Signature: _____