University Health

Authorization to Access, Inspect, and/or Obtain a Copy of Protected Health

Patient Name: _____
Last Name First Name Middle Name

Medical Record Number (MRN): _____ **Date of Birth:** _____/_____/_____

Patient Address: _____
Street City State Zip Code

Patient Phone Number: (_____) _____ **Cell/Work Phone Number:** (_____) _____

I hereby authorize University Health to disclose my Protected Health Information to the following Designee:

❑ **Self: See above information provided for recipient mailing address & contact information.**

Recipient:

_____
Name of person or organization to which disclosure of Protected Health Information is to be made

Recipient Address: _____
Street City State Zip Code

Recipient Phone Number: (_____) _____ **Recipient Fax Number:** (_____) _____

The following information is to be disclosed for the dates of treatment: _____ to _____

❑ Pertinent Packet (H&P, Op, D'C, Labs, X-rays)	❑ Operative/Procedure Reports	❑ Immunization Record
❑ Face Sheet	❑ Laboratory Reports	❑ Consultation Reports
❑ Admit/Discharge Summary	❑ Pathology Reports	❑ Alcohol/Drug Treatment
❑ Emergency Room Treatment	❑ Radiology Digital Images	❑ HIV Related Information
❑ History & Physical	❑ Radiology Reports	❑ Itemized Bill
❑ Progress Notes	❑ Mental Health Info (req. phys. approval)	❑ Entire Record

❑ Other: _____

Disclosure of Protected Health Information will be used for the following purpose(s): ❑ Medical ❑ Legal ❑ Insurance
❑ At The Request of the Individual ❑ Other: _____

Disclosure of Protected Health Information can be delivered by: ❑ Mail ❑ In Office Pick Up ❑ Fax

❑Email: _____

Disclosure of Protected Health Information can be provided by: (Please check one) ❑ Electronic Format (DVD) ❑ Paper

- I acknowledge and hereby consent to the release of information relating to: psychiatric records, alcohol and/or drug abuse records, HIV/AIDS information, genetic testing, and/or sexually transmitted disease information. If you do not wish to have released any of the categories of information described above please specify: _____
- I understand if the recipient authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and no longer be protected by federal and state 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 Health Information Management Department. I understand the revocation will not apply to information that has already be released in response to this authorization.
- I understand that signing this authorization is voluntary. My treatment, payment, enrollment and eligibility benefits with University Health, will not be conditioned upon my authorization of disclosure.
- This authorization shall expire upon release of the information for the purpose stated above, or 180 days (six months) from the date of signature, whichever occurs first.
- A copy of the signed authorization will be provided to the recipient.

_____
Signature of Patient or Patient's Representative **Relationship to Patient** **Date**

Completed authorizations can be mailed or faxed to:

4502 Medical Drive
Attn: Health Information Management MS# 26-2
San Antonio, TX 78229

Fax Number: (210) 358-5936
Phone Number: (210) 358-3532

Identification verified by: ❑ Driver's License ❑ Other Valid Picture ID _____

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