UT Physicians
A Part of UTHealth

Medical Records, 6410 Fannin, LL100, Houston, TX 77030, Ph. 832-325-6543 Fax 713-512-2252

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
(FOR UTP PATIENTS TO REQUEST UTP TO SEND MEDICAL RECORDS TO ANOTHER PROVIDER)

1. I hereby authorize UT Physicians to use and disclose protected health information from the record(s) of:
   Patient's Name (Print): _____Birth date: _____or
   MRN#_____Phone number:_____
2. Copies of the following records shall be used and disclosed:
   ____ Complete Clinical Records; (if requesting **genetic** or **psychotherapy**, please specify.)
   ____ Provider _____
   ____ Other (specifically identify exact information to be disclosed, including **dates of service**)

History and physical exam_____	Laboratory test reports_____	Photographs, videos, etc._____
Consultation reports_____	Discharge Summary_____	Physical Therapy Notes_____
X-ray reports_____	Progress Notes_____	Psychotherapy_____
EKG, Echocardiogram_____	Genetics_____	Other_____

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunoeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

4. I understand that copies of the records indicated above will be: (check one or more, as applicable)

_____ Sent to: Name of Recipient: _____
Name of Company: _____
Address: _____
City_____State: _____ Zip Code:_____

_____ Faxed to: Name of Recipient: _____
Name of Company: _____
Doctors' Offices Only Fax Number: _____
Confirmation Telephone Number: _____

5. I understand there may be a fee assessed for these records.
6. I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.
7. I understand that the purpose(s) of the requested use and disclosure is (are): _____
   _____
   _____
8. I understand that I may revoke this authorization in writing at any time except to the extent that UT Physicians has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to 6410 Fannin, Suite LL 100 Houston, Texas 77030, 713-512-2252 fax.
9. Unless otherwise revoked, this authorization will expire on the 180th day of the signing or as otherwise specified below:_____.
10. I understand that UT Physicians may not condition treatment on my completion of this authorization form.

Signature of Patient or Patient's Legal Representative:_____Date: _____
Printed Name of Legal Representative (if any):_____
Representative's Authority to Act for Patient: _____ (Include copy of legal documents)