

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO UTMB

Patient Name: _____
(PREVIOUS OR OTHER NAMES USED)

Address: _____

Date of Birth: _____ **Social Security Number** (Optional): _____ - _____ - _____

I understand that the specific purpose of this Authorization is (e.g. . to release PHI for treatment or follow up care at UTMB)

I authorize release of medical records FROM: Name: _____
Address: _____ City, State, ZIP
Telephone Number: _____

Please send requested medical records TO: University of Texas Medical Branch- Department or Clinic Name
Address: _____ City, State, ZIP
Telephone Number: _____

I specifically authorize UTMB to obtain the following PHI: (Provide description of the particular medical record information you are requesting be released to UTMB such as date or time period of the requested information)

- Complete Records _____
- Hospital Records _____
- Clinic Records _____
- Radiology Reports _____
- Lab Reports _____
- Operative Reports _____
- Shot Records _____
- Discharge Summary _____
- Other _____

By signing this Authorization Form, I understand that I am giving my authorization for UTMB to receive all protected health information (PHI) relating to my diagnosis, testing or treatment. I understand that my expressed consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. I may revoke this authorization at any time by notifying UTMB in writing to the Health Information Management Department, 301 University Blvd, Galveston, Texas 77555-0782 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by UTMB before UTMB received my written notice of revocation. I understand that the information disclosed pursuant to this authorization may be re-disclosed by UTMB, and any re-disclosure to other recipients may no longer be protected under federal and Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that am not required to sign this Authorization Form in exchange for the patient receiving treatment from UTMB. This authorization will expire on the 180th day of the signing.

Signature of Patient or Authorized Personal Representative

Date

Relationship to the Patient (If signed by a Personal Representative)

IF PATIENT ID CARD IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

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Medical Record Form 7034-Rev. 7/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM.