UTMB USE ONLY: Please check one: _____ HIM to release PHI _____ PHI already has been released; HIM to only file Authorization

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) By UTMB

Patient Name: _____ _____

Last First M.I. (Previous Or Other Names Used)

Address: _____

Date of Birth: _____ **UH Number**: _____

If this Authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

_____

I authorize the release of medical records from: The University of Texas Medical Branch

301 University Blvd. Galveston, Texas 77555

Please release requested medical records to:

Name:

Address:

City: State ZIP

Telephone Number: Fax Number:

I specifically authorize the use and disclosure of the following PHI: **(Please provide a detailed description of the particular data and period of time you are requesting)**

□ Emergency Records	_____	□ Hospital Records	_____
□ Clinic Records	_____	□ Radiology Reports	_____
□ Lab Reports	_____	□ Radiology Films	_____
□ Shot Records	_____	□ Pathology Reports	_____
□ Slides	_____	□ Other	_____

This authorization will expire on the 180th day of the signing unless a lesser date is specified below:

_____

By signing this Authorization Form, I understand that I am giving my authorization for UTMB to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that 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. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from UTMB.

_____ _____

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

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) BY UTMB

Medical Record Form 7032-Rev.5/05

The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM.