UTHealth East Texas

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*(**Not for use to obtain UT Health Behavioral Health Center medical records. See separate form)***

- I hereby authorize UT Health East Texas to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization.
- I understand that this authorization will expire 180 days from the date of signature, unless otherwise revoked. I further understand that I may revoke this authorization at any time by notifying, in writing, the UT Health facility where this authorization originated. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.
- I understand the record might not be complete. If a recent visit, additional information could be added after submitting requested records.
- I understand that this information may include information relating to: AIDS, HIV, diagnosis/treatment of drug or alcohol abuse; mental, behavioral health, or psychiatric care.
- I understand information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.
- I understand that applicable fees may apply, as permitted by Texas law. The fee required for this request is $_____

Patient Information	**Patient Name**			
	Address			
	City/State/Zip			
	Date of Birth	/ /	**Phone #**	

Requesting Facility Information	*Please release information **FROM** these UT Health facilities:* ☐ Tyler ☐ Athens/Cedar Creek Lake ☐ Carthage ☐ Henderson ☐ Rehab ☐ North Campus Tyler ☐ Pittsburg ☐ Quitman ☐ Jacksonville ☐ Specialty ☐ Other:_____
Receiving Facility / Individual Information	*Please release information **TO** the following individual / facility:* Individual/Organization Name | Telephone # Street Address | City, State Zip | Fax #
Indicate Specific Information To Be Released	☐ Summary Abstract (H&P, consultations, discharge summary, test results, procedure reports, pathology) ☐ Discharge Summary ☐ Emergency Department ☐ Laboratory ☐ History/Physical ☐ Operative Report(s) ☐ Radiology Images ☐ Pathology ☐ Radiology Reports ☐ Other: Date(s) of Service:

Record copy format:	☐ Paper	☐ CD	☐ _____	**Delivery Method:**	☐ Pick-up	☐ Mail	☐ Fax	☐ _____

Purpose Of Request	☐ Continued Care	☐ Legal	☐ Insurance / Disability / SSI	☐ Personal	☐ _____

_____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Printed Name of Patient or Legal Guardian Relationship to patient, if other than self (attach appropriate legal documents)

For Hospital Staff use:

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