UTHealth Rio Grande Valley

What Matters To Your Health, Matters To Us™

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

Acct/MR #: _____ Phone: (_____) _____

Address: _____City_____ State_____ Zip_____

I request that my Protected Health Information-PHI from UT Health Rio Grande Valley be disclosed to:

Recipient Name: _____

Address: _____City_____ State_____ Zip_____

Phone: (_____) _____ Fax: (_____) _____
E-mail Address: _____

Purpose for requesting information:

☐ Personal ☐ Continuation of Care ☐ Legal ☐ Disability ☐ Insurance ☐Worker's Compensation

I authorize the following PHI to be released from my medical record(s):

☐ Entire record ☐ Progress Notes ☐ Laboratory Reports □ Operative Reports

☐ Radiology Reports ☐ Discharge Summary ☐ Consultation Reports □ Pathology Reports

☐ Photographs/Videos ☐ EKG/EEG/EMG ☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired or mental health services, and treatment of alcohol abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information to be released/obtained (include dates where appropriate):

☐ Alcohol, Drug, or Substance Abuse Records ☐ HIV Testing and Results ☐ Genetic Records

☐ Mental Health Records ☐ Psychotherapy Records

Dates of Treatment: Specific dates from _____ to _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to UT Health RGV. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire in one (1) year or on the following date: _____
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Printed Name of Patient or Patient Representative Relationship to Patient