



Category: HIPAA Privacy Manual
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Title: Authorization for Release of Protected Health Information

Reference: 45 C.F.R. §§ 160.103, 164.501

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 Use Disorder Records - 42 CFR Part 2 prohibits unauthorized use or disclosure of these 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 RG.
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