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 #**	
	Email Address			

Requesting Facility Information	*Please release information **FROM** these UT Health facilities:*				
	☐ Tyler	☐ Athens/Cedar Creek Lake	☐ Carthage	☐ Henderson	☐ Rehab
		☐ 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:**	☐ My Chart	☐ Email	☐ Fax	☐ Pick Up	☐ Mail

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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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