UNIVERSITY of HOUSTON

HEALTH CENTER

100 UH Health Center Houston, Texas 77204-3019 713-743-5151 • FAX: 713-743-5164

Authorization for Release of Medical Records

					()	-
	Name o	of Patient (Please Print)		Date of Birth		Phone Number
I, the under	rsigned and above-nam	ed patient, authorize the following infor	rmation to be re	eased:		
INFORMAT	TION TO BE RELEASED:					
☐ Nurse's	& Physical s Notes ogy Report	☐ Psychiatric Assessment☐ Provider's Orders/Notes☐ At patient's request☐ ☐	Other:	☐ Progress Report☐ Consultation Rep	ort	☐ Immunizations ☐ Lab Report
	,6)epo.t	= // patient s request			Please Print	
illness, or c	ommunicable disease,	rmation to be released may include, but including Human Immunodeficiency Virus of information relating to:		,, ,	•	,
, , , ,			•	□ Psychotherapy Notes □ HIV related information (including AIDS relating testing)		
I request co	ppies of my medical rec	ords to be transferred (initial which option	on(s) apply):			
	то:				FROM:	UH Health Center
	Print N	lame of Organization (Doctor, Hospital, A	ttorney, Insuranc	e Company, Self, etc.)		
Initials	Complete address of	organization from which disclosure is to b	be made			
	TO: UH Health	Center FROM:				
	To: Off ficulting		Name of Organiza	ation (Doctor, Hospital, A	Attorney, Insurance	Company, Self, etc.)
Initials						
	Complete address of	organization from which disclosure is to b	be made			
PATIENT IN	NFORMATION IS NEEDE	D FOR:				
☐ Continu☐ Military☐ Other:	•	☐ Insurance ☐ Personal Use		Security/Disability Purposes	☐ School	
			Please Pr	nt		
or disclosed privacy reg treatment is respective of to the exter I understan- programs, of my medical any time ex	d pursuant to this auth ulations. However, oth information, HIV/AIDS-employees, officers, he it indicated and author d that treatment or payor authorization of the records. I understand reept to the extent that	confidential and cannot be disclosed with orization may be subject to redisclosure ner state or federal law may prohibit the related information, and psychiatric/mealth care providers and agents are herebized herein. The ment cannot be conditioned on my signification of testing results for pre-employming treatment will not be conditioned by reaction has been taken in reliance upon the conditioned on my signification of the conditioned by reaction has been taken in reliance upon the conditioned by the conditioned by the conditioned by the conditioned by the condition of the con	e by the recipient fro the recipient fro ental health info y released from ng this authorization of my completion of ne authorization.	t and may no longer be m disclosing specially p rmation. The Universi- any legal responsibility of tion, except in certain ci- anderstand I may be cha this form. I understand If this authorization is n	e protected by fed protected informat ty of Houston, the or liability for disclo rcumstances such a orged a retrieval/pro that I may revoke	eral or state HIPAA or medication, such as substance abuse UH Health Center, and their osure of the above information as for participation in research occasing fee and for copies of this authorization in writing at
By signing b	oelow, I acknowledge t	hat I have read and understand this Auth	norization.			
Signature o	f Patient or Legally Auth	norized Representative			Date	
Printed Nan	ne of Patient or Legally	Authorized Representative	Autho	rity to Sign if not Patient	t:	
		FOR	R OFFICE USE ON	Y		
Date Reque	est Processed:	Ву:	Identi	ication Presented:		Payment: