Form No. OGC-SF-2005-03

Authorization for Release of Medical Records

Name of Patient: ____ Date(s) of Service: ______________________________
(please print)
Date of Birth: ____

I, the undersigned and above-named patient, authorize the release of or request access to the information specified below from the medical record(s) of the undersigned and above-named patient.

PATIENT INFORMATION IS NEEDED FOR:

___ Continuing Medical Care ___ Insurance ___ Social Security/Disability ___ School
___ Military ___ Personal Use ___ Legal Purposes
___ Other: ____
(please print)

INFORMATION TO BE RELEASED OR ACCESSED:

___ History & Physical ___ Psychiatric Assessment ___ Progress Report ___ Dr. Notes
___ Nurse Notes ___ Dr. Orders ___ Consultation Report ___ Lab Report
___ Radiology Report ___ X-Ray Films/Copies ___ Other: ______________________________________
(please print)

The above information may be released to (specify name or title of individual or the name of the organization to which records are to be released and the appropriate address):

____ ______________________________
Printed name of Doctor, Hospital, Attorney, Insurance Company, Self, etc. Phone Number

____
Printed Address (Street, City, State, Zip Code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.* I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand I may be charged a retrieval/processing fee and for copies of my medical records. I understand my treatment will not be conditioned by my completion of this form. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. If this authorization is not earlier revoked, this authorization shall terminate on ____________________, or within six months from today's date, whichever occurs sooner.
(please print)

Signature: ____ Date: __________________________
Patient or Legally Authorized Representative

____ ______________________________
Printed Name of Patient or Legally Authorized Representative Relationship to Patient

* To the third party receiving alcohol or drug abuse patient records: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part II. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

UH Staff Only

Date Released: _______________________ Released By: ____
Notes: ____
____

Note: Modification of this Form requires approval of OGC

Standard Form Approved
by the University of Houston System
Office of the General Counsel
Office of Contract Compliance