University Health System

Authorization to Access, Inspect, and/or Obtain a Copy of Protected Health Information

Patient Name: _____
Last Name First Name Middle Name

Medical Record Number (MRN): _____ **Date of Birth:** _____/_____/_____

Patient Address: _____
Street City State Zip Code

Patient Phone Number: (_____) _____ **Cell/Work Phone Number:** (_____) _____

I hereby authorize University Health System to disclose my Protected Health Information to the following Designee:

❑ Self: See above information provided for recipient mailing address & contact information.

Recipient: _____
Name of person or organization to which disclosure of Protected Health Information is to be made

Recipient Address: _____
Street City State Zip Code

Recipient Phone Number: (_____) _____ **Recipient Fax Number:** (_____) _____

The following information is to be disclosed for the dates of treatment: _____ to _____

- ❑ Pertinent Packet (H&P, Op, D'C, Labs, X-rays)
- ❑ Face Sheet
- ❑ Admit/Discharge Summary
- ❑ Emergency Room Treatment
- ❑ History & Physical
- ❑ Progress Notes
- ❑ Operative/Procedure Reports
- ❑ Laboratory Reports
- ❑ Pathology Reports
- ❑ Radiology Digital Images
- ❑ Radiology Reports
- ❑ Mental Health Information (requires physician approval)
- ❑ Immunization Record
- ❑ Consultation Reports
- ❑ Alcohol/Drug Treatment
- ❑ HIV Related Information
- ❑ Itemized Bill
- ❑ Entire Record

❑ Other: _____

Disclosure of Protected Health Information for the following purpose(s): ❑ Medical ❑ Legal ❑ Insurance
❑ Other: _____

Disclosure of Protected Health Information should be delivered by: ❑ Mail ❑ In Office Pick Up ❑ Fax (Healthcare Only)
❑ Other (Unable to e-mail): _____

Disclosure of Protected Health Information should be provided on: (Please check one) ❑ Electronic Format (DVD) ❑ Paper

- I acknowledge and hereby consent to the release of information relating to: psychiatric records, alcohol and/or drug abuse records, HIV/AIDS information, genetic testing, and/or sexually transmitted disease information. If you do not wish to have released any of the categories of information described above please specify: _____
- I understand if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state regulations.
- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already be released in response to this authorization.
- I understand authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.
- This authorization shall expire upon release of the information for the purpose stated above, or 180 days (six months) from the date of signature, whichever occurs first.

_____

Signature of Patient or Patient's Representative **Relationship to Patient** **Date**

Completed authorizations can be mailed or faxed to:

4502 Medical Drive
Attn: Health Information Management MS# 26-2
San Antonio, TX 78229

Fax Number: (210) 200-6002
Phone Number: (210) 358-3532

Identification verified by: ❑ Driver's License ❑ Other Valid Picture ID _____ HIM Staff Employee ID: _____