



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

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

- Checkboxes for various medical records: Pertinent Packet, Face Sheet, Admit/Discharge Summary, etc.

Other: \_\_\_\_\_

Disclosure of Protected Health Information will be used for the following purpose(s): Medical Legal Insurance

Disclosure of Protected Health Information can be delivered by: Mail In Office Pick Up Fax Other:

Disclosure of Protected Health Information can be provided by: (Please check one) Electronic Format (DVD) Paper

- Legal disclaimer text: 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.

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

BCHD# 282 Rev. 03/2021 Copy Provided to Patient HIM Staff Employee ID:

