University Health
4502 Medical Drive
Medical Records Department, MS#26-2
San Antonio, Texas 78229-4493
(210) 358- 3532

Authorization to Allow Designated UHS Employee to Access, Inspect, and/or Obtain a Copy of Health Information

I, _____, hereby authorize _____ who is an employee
Patient's Name **Employee Name**

of University Health to access, inspect and/or obtain a copy of my Health Information. I understand that this authorization limits the designated employee to print no more than ten (10) pages of Health Information. If a greater quantity is required, I am required to submit a separate Authorization to the Medical Records Department, Release of Information.

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Phone: (_____)_____ Date of Birth: _____ MRN: _____

Type of information to be accesses, inspected and/or copied (check the appropriate boxes and include other information where indicated.)

□ Emergency Center Visits	□ Consultation Reports	□ Physician's Orders	□ Inpatient Record
□ Radiology Reports/Films	□ Operative Reports	□ Discharge Summary	□ Laboratory/Pathology Reports
□ Progress Notes	□ Nurses Notes	□ History & Physical	□ Other, please specify
□ Immunization Records	□ Outpatient Visits/dates: _____		

This information for which I am authorizing access and a copy of will be used for the following purpose:

□ My personal record	□ Continuity of Care	□ Attorney	□ Insurance
□ Disability claim	□ Other (please describe): _____		

PATIENT

I understand this authorization will expire on (Date) _____ or 1 year from the date of this signed authorization, whichever occurs first. (Note: Authorization must be renewed every year)

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 Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization. University Health is released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand if the recipient authorized to receive the information re-disclosed the health information the released information is no longer protected by federal and state regulations. My treatment, payment, enrollment and eligibility benefits with University Health , will not be conditioned upon my authorization of disclosure. I understand that signing this authorization is voluntary. A copy of the signed authorization will be provided to the recipient.

EMPLOYEE

I understand that if this authorization is for my child who is a minor over the age of twelve (12), who may have sought and/or received health care services that did not require my parental consent, such as treatment related to pregnancy, sexually transmitted communicable diseases (HIV, Chlamydia), Chemical Dependency, and/or Mental Health services, then I can not independently access, inspect, or copy that health information.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____ _____
Employee Signature Relationship to Patient Date

FOR MEDICAL RECORDS DEPARTMENT USE ONLY Auth Received on _____ (Date) By MR Employee _____ (Name)
☐ Copy Given to Recipient ☐ For No MRN, Given Additional Form
Identification Verified by: ☐ Driver License ☐ UHS Employee ID ☐ Other Picture ID
Authorization Expires on _____ (Date) (Specified date or 1 year from date patient signed authorization)
Authorization Scanned in Patient's Medical Record on _____ (Date) By MR Employee _____ (Name)

SUBMIT