University Health

University Health System, 4502 Medical Drive, Medical Records Department, MS 26-2, San Antonio, TX 78229-4493
Phone number: (210) 358-3532 Fax number: (210) 358-5936

Authorization to Request Health Information From Another Health Care Provider or Facility

I hereby authorize_____
health care provider or facility to disclose my Health Information as contained in the Designated Record Set, including but not limited to highly confidential information concerning communicable diseases, HIV, AIDS, psychiatric, chemical or alcohol dependency, laboratory test results, or any other medical treatment. This authorization does not include psychotherapy notes.

UHS Medical Record Number: _____ Date of Birth: _____

Print Patient's Name:_____
Last First Middle

Home Address:_____
Street City State Zip Code

RECIPIENT: Name and address of the recipient where my health information should be delivered:

Clinic/Department Name: _____ **Attn:** _____
Clinic/Department Address: _____ **Phone:** _____
Clinic/Department Mail Stop: _____ **Fax:** _____
San Antonio, Texas Zip: _____

Description of the purpose of the use and/or disclosure: **Continuity of Patient Care**

Description of information to be released.(check all that apply)

☐ Emergency Center Visits	☐ Consultation Reports	☐ Inpatient Record/discharge date:
☐ Physician's Orders	☐ Radiology Reports/Films	_____
☐ Operative Reports	☐ Discharge Summary	
☐ Laboratory Reports	☐ Progress Notes	
☐ Nurses Notes	☐ Outpatient Visits/dates: _____	
☐ History & Physical	☐ Other, please specify_____	

- I understand this authorization will expire on _____or 180 days from the date of this signed authorization.
Date
- I understand that 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 privacy regulations.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been 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 healthcare 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.

_____ _____ _____
Signature of Patient or Personal Representative Description of Authority Date

TO BE PLACED IN MEDICAL RECORD

SUBMIT