UT Health San Antonio

Patient Authorization for Use of Health Records
for
Purposes other than Treatment and UT Health San Antonio Education

1. I authorize _____ to disclose

   information from the health records of: _____
   (patient)

   Account #: _____ Date of Birth: _____

2. **Purpose of the disclosure**: _____

3. **Dates of Treatment:** From: _____ To: _____

   Specific reports to be disclosed:

   - ❑ Progress Notes
   - ❑ Discharge Summary
   - ❑ X-ray films or other images
   - ❑ Laboratory Reports
   - ❑ Radiology Reports
   - ❑ Photographs/Videotapes
   - ❑ Operative Reports
   - ❑ Consultation Reports
   - ❑ Records from other facilities
   - ❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
   - ❑ Other(Specify):_____

   I give specific authorization to disclose the following information:

   - ❑ HIV test results
   - ❑ Drug and alcohol abuse treatment records
   - ❑ Documentation of AIDS diagnosis
   - ❑ Psychiatric/Mental Health treatment records

   I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying UT Health San Antonio in writing.

   My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

   Unless revoked earlier, this authorization expires in <u>one year</u> unless I specify another time: _____

   I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____	_____
Signature of Patient (or Patient Representative)	Date
_____	_____
Printed Name of Patient or Patient Representative	Authority of Representative to Act for Patient (Relationship to Patient)

* Need to ensure separate E-mail Authorization Agreement is signed.
Note: Release of Psychotherapy notes requires a separate authorization.