

UTMB Release of Information
301 University Blvd., Galveston, TX 77555-0782
PH (409) 772-1965 FX (409) 772-5101

The information from the hospital medical records on (Patient's Information):

Name: _____ Date of Birth: _____

Address: _____
No. & Street name City State Zip Code

Phone Number: _____

I hereby authorize UTMB health to release to:

Name/Facility Name of Recipient: _____

- By mail – Address: _____
- By fax – Fax number: _____
- By email – Email address: _____
- via MyChart Patient Portal (An active MyChart account is required for this option)

If you choose the option to have your PHI sent to you through email please be aware that UTMB's email system is configured to send encrypted email, but not all other email servers can accept encrypted email. This means that email communications to you from UTMB may not be encrypted and, as a result, a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it. Signing below indicates that you understand the risks of unencrypted email and give permission to UTMB to send you the PHI associated with this request via email.

I hereby authorize the release of the following information, including, if applicable, any treatment or test results for mental health, alcohol and/or drug abuse, or reportable communicable diseases, including acquired immune deficiency syndrome or human immuno-deficiency virus infection.

- Entire Medical Records
- Partial Records: From _____ Start _____ to _____ End _____
- Description of records (diagnosis, department, physician, etc.) _____
- Other (please specify) _____

Expiration:

____ This request is for a one time release.

____ This request is ongoing until withdrawn in writing to:

UTMB Release of Information, 301 University Blvd., Galveston, TX 77555-0782 or Fax (409) 772-5101.

Patient signature: _____ Date: _____

OR

Signature of legal representative: _____ Name of legal representative: _____

Relationship to patient: _____

Please complete this request and submit to UTMB Release of Information

Mail: 301 University Blvd., Galveston, TX 77555-0782

Fax: (409) 772-5101

Email: himrio@utmb.edu

IF PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

PATIENTS REQUEST FOR MEDICAL RECORDS

Medical Record Form 7033-04/23
**The University of Texas Medical Branch Hospitals
Galveston, Texas**

Original-Medical Record