

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 \_\_\_\_\_ to \_\_\_\_\_  
Start 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\_\_\_\_ This request is ongoing until withdrawn in writing to: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

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM

ADDITIONAL FORMS MAY BE OBTAINED FROM UTMB PRINTING SERVICES BY CALLING 409.772.5900