HIPAA AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) By UTMB

Patient Name: _____ _____
Last First M.I. (Previous Or Other Names Used)

Address: _____

Date of Birth: _____ **MRN** (If known) _____

Please state the purpose of your request for patient's records below:

I authorize the release of medical records from:

UTMB at Galveston
301 University Blvd.
Galveston, TX 77555-0782
Phone (409) 772-1965 Fax (409) 772-5101

Please release requested medical records to:

Name: _____

Address: _____

City: _____ State____ ZIP_____

Tel: _____ Fax: _____

I specifically authorize the use and disclosure of the following PHI: **(Please provide a detailed description of the particular data and period of time you are requesting)**

- ❏ Emergency Records _____
- ❏ Clinic Records _____
- ❏ Lab Reports _____
- ❏ Immunization Records _____
- ❏ Slides _____
- ❏ Hospital Records _____
- ❏ Radiology Reports _____
- ❏ Radiology Films _____
- ❏ Pathology Reports _____
- ❏ Other _____

This authorization will expire on the 180th day of the signing unless a lesser date is specified below: _____

By signing this Authorization Form, I understand that I am giving my authorization for UTMB to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying UTMB in writing to UTMB 301 University Blvd., Galveston, TX 77555-0782 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by UTMB before UTMB received my written notice of revocation. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from UTMB.

_____ _____ _____
Signature of Authorized Personal Representative Date/Time Relationship to the Patient

*****Please attach documents to verify your authority to sign on behalf of the patient: Letter of Representation, Medical Power of Attorney, Guardianship Letters, etc.*****

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

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM

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

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) BY UTMB HHSC DSHS

Medical Record Form 7032-Rev.–5/24

The University of Texas Medical Branch Hospitals Galveston, Texas

Original–Medical Record