UT-HARRIS COUNTY PSYCHIATRIC CENTER P.O. BOX 20249 Houston, Texas 77225-0249 **AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION**	Release of Information Fax Number 713-741-3870 Main Number 713-741-7888

NAME OF PATIENT_____ HCPC MR#_____

DATE OF BIRTH_____

I authorize HCPC to release the following health
(Name of Facility)
information or medical records, information. I understand that if the health information or medical records contain information about a diagnosis of, or treatment for, alcoholism, or substance abuse and/or addiction, or a communicable disease or sexually transmitted disease, (including acquired immune deficiency syndrome or human immuno-deficiency virus infection), this authorization will include authorization for the release of such information.

I am authorizing the use or disclosure of the following information:

____Discharge Summary	____Physician Orders	____History	____Laboratory Reports
____Progress Notes	____Radiology Reports		____Psychological Evaluation
____Consultation Report	____EEG Report	____Psychological Testing Report	
____Other_____			

I am requesting this information for the following purpose: (Please Circle)

1. Filing insurance claims 2. Continued care by another physician or healthcare facility
3. Disability determination 4. At the request of the individual 5. Other (List below)

_____

I authorize disclosure to the following person or organization:

_____
Name of person/organization

Potential For Re-Disclosure

The information to be disclosed comes from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit the recipient of these records from making further disclosure of it without specific written consent of the person to whom the records pertain, or as otherwise permitted by such regulations.

Expiration Date Of Authorization:

Expiration Date:_____ **or** Expiration Event: _____
NOTE: I understand that unless I choose a specific authorization date, this authorization is effective for ninety days unless I revoke it sooner.

Right To Terminate Or Revoke Authorization

I may revoke or terminate this Authorization by submitting a written revocation to UTHCPC. Exception: When I revoke an authorization, the revocation is only valid from the time UTHCPC receives the revocation. The revocation has no effect on information that has already been released.

I understand that UTHCPC cannot make me sign this document, and if I refuse to sign this authorization, UTHCPC may not refuse to treat me.

_____ _____
Signature of Patient or Representative Date

_____ _____
Relationship to Patient (if Representative) Signature of Witness