| UTHealth Houston Behavioral Sciences Campus<br>P.O. BOX 20249<br>Houston, Texas 77225-0249<br><br>**AUTHORIZATION TO RELEASE** | Release of Information<br>Fax Number 713-383-3749<br>Main Number 713-741-7888<br>Email BSCMedRecords@uth.tmc.edu |
|---|---|

NAME OF PATIENT_____ MEDICAL RECORD # _____

DATE OF BIRTH_____

I authorize UTHealth Houston Behavioral Science Campus 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 ____History and Physical _____Laboratory Reports
____Progress Notes _____Physician Orders _____Psychological Evaluation
____Consultation 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 Phone/ Fax Number

_____
Address City, State, zip code

**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. Exception: When I revoke an authorization, the revocation is only valid from the time UTHealth Houston Behavioral Science Campus receives the revocation. The revocation has no effect on information that has already been released.
I understand that UTHealth Houston Behavioral Science Campus cannot make me sign this document, and if I refuse to sign this authorization, may not refuse to treat me.

_____ _____
Signature of Patient or Representative Date

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