UTHealth™
The University of Texas
Health Science Center at Houston

Patient's Name: _____

Birth date: _____

Authorization for the Use and Disclosure of Protected Health Information

I request and direct Student Health and Counseling Services to release my records to the Student Affairs Office of my school at UTHealth.

This authorization permits the Student Health and Counseling Services to disclose Student Health's decision to place me on mandatory leave and decision to return to school.

I understand that the information indicated above will be provided to the UTHealth Student Affairs Office of

- ☐ Cizik School of Nursing
- ☐ McGovern Medical School
- ☐ MD Anderson UTHealth Graduate School
- ☐ School of Biomedical Informatics
- ☐ School of Dentistry
- ☐ School of Public Health

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that the purpose(s) of the requested use and disclosure is to determine suitability to return to school.

I understand that I may revoke this authorization in writing at any time except to the extent that the covered entity has already relied on this authorization. I understand that I may revoke this authorization by sending a written notice to Student Health and Counseling Services, UT Professional Building, 6410 Fannin St. Suite 130, Houston, TX 77030 stating my intent to revoke this authorization.

Unless otherwise revoked, this authorization will expire on the 180th day of the signing or as otherwise specified below: _____.

I understand that Student Health and Counseling may not deny me treatment if I do not my complete this authorization form.

Signature of Patient: _____

Date: _____