UTHealth Neurosciences
The University of Texas Health Science Center at Houston

Medical Records, 6400 Fannin, Suite 2150, Houston, TX 77030, Ph. 713-486-8100 Fax 713-486-8101

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(FOR UTHN PATIENTS TO REQUEST UTHN TO SEND MEDICAL RECORDS TO SELF, ANOTHER PROVIDER or OUTSIDE ENTITY)

1. I hereby authorize UTHealth Neurosciences to use and disclose protected health information from the record(s) of:
   Patient's Name (Print) _____ Birth Date: _____ or
   Or MRN # _____ Phone Number: _____

2. Copies of the following records shall be used and disclosed:

_____ Complete Clinical Records; (if requesting **genetic** or **psychotherapy**, please specify.)
_____ Provider _____
_____ Other (specifically identify exact information to be disclosed, including **dates of service**)

History & Physical Exam _____	Laboratory test reports _____	Photographs, videos, etc _____
Consultation reports _____	Discharge Summary _____	Physical Therapy Notes _____
X-ray reports _____	Progress Notes _____	Psychotherapy _____
EKG, Echocardiogram _____	Genetics _____	Other _____

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental and behavioral health or psychiatric care.

4. I understand that the copies of the records indicated above will be: (check one or more, as applicable)

_____ Sent to: Name of Recipient: _____
Name of Company: _____
Address: _____
City: _____ State: _____ Zip: _____

_____ Faxed to: Name of Recipient: _____
Name of Company: _____
Doctors' Offices Only Fax Number: _____
Confirmation Telephone Number: _____

5. I understand there may be a fee assessed for these records.

6. I understand that to the extent of 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.

7. I understand that the purpose(s) of the requested use and disclosure is (are):_____
_____
_____

8. I understand that I may revoke this authorization in writing at any time except to the extent that UTHealth Neurosciences has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to 6400 Fannin, Suite 2150 Houston, TX 77030, 713-486-8101 fax.

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

10. I understand that UTHealth Neurosciences may not condition treatment on my completion of this authorization form.

Signature of Patient or Patient's Legal Representative: _____ Date: _____
Printed Name of Legal Representative (if any): _____
Representative's Authority to Act for Patient: _____ (include copy of legal documents)