WE MAKE LIVES BETTER
UT MEDICINE SAN ANTONIO
UT HEALTH SCIENCE CENTER

UT Medicine Women's Health Center
8300 Floyd Curl Dr.
San Antonio, Texas 78229
Phone: 210-450-9500 Fax: 210-450-6028

1. I authorize _____Phone:_____Fax:_____ to disclose information from the health records of: _____
(patient)
MRN #: _____ Date of Birth: _____

2. The information is to be disclosed to: _____ **UT Medicine Women's Health Center**
Address (sender/receiver if other than UT Health Science Center): ____ **8300 Floyd Curl Dr. – MC 7977**
City, State, Zip: _____ **San Antonio, Texas 78229**
Contact Person: _____ **Attn: Janie Arroyo**
Phone/Fax: _____ **210-450-9531 / 210-450-6028**

I authorize this information to be disclosed in the following ways:
❑ Written/Photocopy/Paper ❑ Verbal ❑ Fax ❑ Electronic Mail *

Purpose of the disclosure: _____

3. **Dates of Treatment:** From: _____ To: _____

Specific reports to be disclosed:
❑ Progress Notes ❑ Laboratory Reports ❑ Operative Reports
❑ Discharge Summary ❑ Radiology Reports ❑ Consultation Reports
❑ X-ray films or other images ❑ Photographs/Videotapes ❑ Records from other facilities
❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
❑ Other(Specify):_____

I give specific authorization to disclose the following information:
❑ HIV test results ❑ Documentation of AIDS diagnosis
❑ Drug and alcohol abuse treatment records ❑ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying UT Health Science Center in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient (Relationship to Patient)