THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO
Department of Obstetrics & Gynecology, South Texas Women's Health Center
8122 Datapoint, Suite 1300, San Antonio, TX 78229-3264
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Patient Authorization for Release of Health Records

1. I authorize _____
Street Address: _____
City, State, Zip: _____
Phone_____ Fax _____
To disclose information from the health records of: _____
(patient)

MRN#: _____ Date of Birth: _____

2. The information is to be disclosed to:
Address (sender/receiver if other than UTHSCSA) South Texas Women's Health Center

I authorize this information to be disclosed in the following ways:
Written/photocopy/paper ❑Verbal ❑Fax ❑Other electronic means

Purpose of the disclosure: _____

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

Specific reports to be disclosed:
- ❑ Progress Notes ❑ Discharge Summary ❑ Laboratory Reports
- ❑ Radiology Reports ❑ Operative 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 ❑ Any documentation of AIDS diagnosis
- ❑ Drug and alcohol abuse treatment records ❑ Psychiatric/Mental Health treatment records. (Note: Release of Psychotherapy Notes requires a separate authorization.)

I understand the following:

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 the UTHSCSA in writing at: [contact person and title; address].

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.

_____ _____
Signature of Patient (or Patient Representative) Date

_____
Printed Name of Patient or Patient Representative

_____
Authority of Representative to Act for Patient
(Relationship to Patient)