UNIVERSITY OF TEXAS ARLINGTON

Health Services

Authorization for the Use and Disclosure of Protected Health Information to Outside Entity

Form 9-8
09/14/2011

1. I hereby authorize _____ to disclose protected health information to UT Arlington Health Services from the record(s) of:

Patient's Name: _____ Contact Telephone Number: _____

UTA ID Number: _____ Date of Birth: _____

A legible copy of a photo identification must accompany this authorization

2. **Release is for the purpose of:**

- ☐ Continued care by other health care provider
- ☐ Insurance
- ☐ Attorney
- ☐ School
- ☐ Personal Review
- ☐ Other (Please specify) _____

Information to be released (indicate dates):

- ☐ Medical Records
- ☐ Lab Results
- ☐ Psychological records
- ☐ X-Ray Film
- ☐ Specific Specialty
- ☐ Other (Please specify) _____

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

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

☐ **Sent to:**

Name of Recipient: _____

UT Arlington Health Services
Box 19329
Arlington, TX 76019

☐ **Faxed to:**

Name of Recipient: _____

UT Arlington Health Services
Fax Number: 817-272-3829
Confirmation Telephone: 817-272-2771

5. I understand that since the Recipient of this information, as identified above, is a "covered entity" under Federal or Texas privacy law, the information is protected by Federal and Texas law once it is disclosed to the Recipient and, therefore, is not subject to re-disclosure by the Recipient.

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

- ☐ At the request of the individual
- ☐ Other: _____

7. I understand that I may revoke this authorization in writing at any time except to the extent that _____ has already relied on this authorization. I understand that I may revoke this authorization by providing a written notice to _____ _____ stating my intent to revoke this authorization.

8. Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is: 90 days from date of signature.

9. I understand that _____ 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: _____

UT Arlington Health Services complies with all applicable Texas medical privacy statutes including Occupations Code Chapter 159 and Health & Safety Code Chapter 611 related to information obtained as a result of patient treatment. Health Services will safeguard the privacy and confidentiality of all such information.