UTA Health Services
DIVISION OF STUDENT AFFAIRS

Form 9-7
06/27/2023

Box 19329 605 S. West St. Arlington, TX 76019 T. 817-272-2771 F.817-272-3829 www.uta.edu/healthservices

UTA Health Services
Authorization for the Use and Disclosure of Protected Health Information

1. I hereby authorize UTA Health Services to use and disclose protected health information from the records of:

Patient's Name
UTA ID Number
Contact Telephone Number
Date of Birth

***A legible copy of photo identification must accompany this authorization. ***

2A. Release is for the purpose of:
- ☐ Continued care by other health care provider
- ☑ Insurance
- ☐ Attorney
- ☐ School
- ☐ Personal review
- ☐ Other (please specify)

2B. Information to be released (indicate dates)
- ☐ Medical records
- ☐ Lab results
- ☐ Psychological records
- ☐ Psychiatry records
- ☐ X-ray reports
- ☐ Immunization records
- ☐ Other (please specify)

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 misuse, or mental or behavioral health 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
Name of Company
Address

☐ Faxed to:
Name of Recipient
Name of Company
Fax Number
Confirmation Phone Number

5. 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; therefore, it may be 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 (please specify)

7. I understand that I may revoke this authorization in writing at any time except to the extent that UTA Health Services has already relied on this authorization. I understand that I may revoke this authorization by faxing (817-272-3829) or mailing a written notice stating my intent to revoke this authorization to: Health Services Director, UTA Health Services, Box 19329, Arlington, TX 76019.

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

9. I understand that UTA Health Services may not condition treatment on my completion of this authorization form.

Signature of Patient or Legal Representative
Date
Printed Name of Patient's Legal Representative
Representative's Authority to Act for Patient

UTA 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. UTA Health Services will safeguard the privacy and confidentiality of all such information.