UNIVERSITY OF TEXAS ARLINGTON

Health Services

Form 9-7
09/14/2011

Authorization for the Use and Disclosure of Protected Health Information

Box 19329 605 S. West St. Arlington, TX 76019 T.817.272.2771 F.817.272.3829 www.uta.edu/healthservices

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

Patient's Name: _____ Contact Telephone Number: _____

UTA ID Number: _____ Date of Birth: _____

*** A legible copy of 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 speciality
- ■ Other(please specify) DRUG SCREEN RESULTS

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immuno deficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; 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: UTA COLLEGE OF NURSING

Address: _____

_____

☐ Faxed to:

Name of Recipient: _____

Name of Company: _____

Fax Number: _____

Confirmation Telephone Number: _____

5. I understand that to the extent 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.

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 UTAHS 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, UT Arlington Health Services, Box 19329, Arlington, TX 76019.

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 UTAHS 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: _____

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.