AUTHORIZATION TO RECEIVE MEDICAL RECORDS

I authorize the doctor or healthcare provider named below to release the medical record(s) or health information of the patient below to <u>UT Health Austin, 1601 Trinity Street Austin, TX 78712, 1-833-UT-CARES, FAX: 512-495-5680.</u>

Patient Information		Healthcare Provider Information
Name:		Name:
Other names used:		Phone:
Date of birth:		Address:
Phone:		
Address:		
		Dates of Treatment:
Medical Record #:		
I ask that the following be g	ven to UT Health Austin (selec	et any items you want sent to UT Health Austin*):
All medical records	□ Past/Present Med	
History & Physical	☐ Diagnostic Test I	
Discharge Summary Billing Information	□ Radiology Repor□ Lab Results	ts & Images
6		
	•	of a minor patient may be required for the release of some of these items.
		ntal health, alcohol/substance abuse, HIV/AIDS test
	on will be disclosed VFC DIF	ASE DISCLOSE:
results, or genetic information	on win be disclosed. IES, IEE	
Mental Health Records (e	xcluding psychotherapy notes)*	HIV/AIDS Test Results/Treatment
	xcluding psychotherapy notes)*	
Mental Health Records (e	xcluding psychotherapy notes)*	HIV/AIDS Test Results/Treatment
Mental Health Records (e	xcluding psychotherapy notes)* ace Abuse Records	HIV/AIDS Test Results/Treatment Genetic Information
Mental Health Records (eDrug, Alcohol, or Substantantantantantantantantantantantantant	xcluding psychotherapy notes)* ace Abuse Records a one):	HIV/AIDS Test Results/Treatment Genetic Information *Release of psychotherapy notes requires a separate Authorization
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Mental Health Records (eDrug, Alcohol, or Substand Reason for Disclosure (select Treatment/ Continuing At the Request of Pati This authorization will be in eff By signing below, I agree: I may withdraw my permis above. However, any disclosure of the healthcare provided to sign to the voluntary, and I may refus. I release the healthcare provided to this form. I have read this form and disclosed pursuant to this longer be protected by fed. Signature of Patient or Representation.	scluding psychotherapy notes)* ace Abuse Records a one): a Medical Care ent fect for one year or until sion at any time. If I withdraw mosures already made based on the covider listed above in writing, his form to receive treatment or the to sign it. I may request a copy ovider listed above from legal residues to the uses and disclosures Authorization may be subject to the eral or state privacy laws.	HIV/AIDS Test Results/Treatment Genetic Information *Release of psychotherapy notes requires a separate Authorization *Other