**UNIVERSITY MEDICAL CENTER**
602 INDIANA AVENUE
LUBBOCK, TEXAS 79415

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

## IDENTITY OF PATIENT

UMC RELEASE OF INFORMATION
Office 806-775-9150, Fax 806-775-9157

Patient Name: _____ Date of Birth: _____

Address: _____ Med Rec #: _____

_____ Visit #: _____

## WHO MAY MAKE THE DISCLOSURE

I request and authorize the following entity and its employees and agents to release information relating to the diagnosis, care, and treatment of the above-named patient:

University Medical Center; 602 Indiana Avenue; Lubbock, TX 79415

## TO WHOM THE DISCLOSURE MAY BE MADE

If requesting that requested records be faxed, please remember to include return fax number below.

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

## WHAT INFORMATION TO DISCLOSE

The type and amount of information to be used or disclosed is as follows:
*Check appropriate item(s) and include other information where indicated*.

- ❑ All Medical Records _____
- ❑ Medical Records from _____ (date) to _____ (date)
- ❑ Other (please specify): _____

_____

**I understand that information in my health record may include information relating to:**
(1) AIDS/HIV test results, infection status, or treatment information; (2) sexually transmitted disease; (3) treatment for alcohol and drug abuse; (4) behavioral and mental health services; (5) Genetic Testing.
**I AUTHORIZE THE DISCLOSURE OF THIS INFORMATION EXCEPT AS FOLLOWS:**

_____

_____

## PURPOSE OF DISCLOSURE

This information is being released for the following purpose(s):

- ❑ Continued care by other health care provider
- ❑ Attorney
- ❑ Insurance
- ❑ Disability Determination
- ❑ School
- ❑ At the request of the individual
- ❑ Personal Review
- ❑ Other: _____

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# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

## TERMS OF DISCLOSURE

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to:

Records Custodian, Health Information Management
University Medical Center
602 Indiana Avenue
Lubbock, TX 79415

I understand that the revocation will not apply to information that has already been released in response to this information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

If I fail to specify an expiration date, event, or condition, this authorization will expire 180 days from the date of signing.

I have read this form and agree to the uses and disclosures of the information as described.

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that I need not sign this order to ensure health care treatment.

I fully understand and accept the terms of this authorization.

| SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE | DATE | TIME |
|---|---|---|

| PRINT NAME OF REPRESENTATIVE (IF APPLICABLE) | REPRESENTATIVE RELATIONSHIP TO PATIENT |
|---|---|

## OFFICE USE ONLY

- ❑ Authorization verified by _____ on _____ (date)
- ❑ Patient has been provided with a copy of the signed authorization.