

Authorization for Release of Medical Information

Patient's name: _____	Date of Birth: _____
Address: _____	
City/State/Zip Code: _____	
SS#: _____	Patient's phone #: () _____
Date of Request: _____	Date Needed: _____

OR	
<input type="checkbox"/> I authorize UT Imaging-Houston, LLP to release information to: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)	<input type="checkbox"/> I authorize UT Imaging-Houston, LLP to obtain information from: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) Healthcare Other

TYPE OF RECORDS REQUESTED: (Check one.)

- Specific information (Select one or more, as applicable)
- Diagnostic Testing reports/films Breast Imaging films/reports including mammogram/ultrasounds
 - Other _____
(Please describe.)

AUTHORIZATION VALID FOR: (Check one.)

- This request only.
- One year from the date of this authorization **OR** _____. (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
- This request **and** for medical records of any **future** treatment of the type described above until: _____
Insert Date

<p><i>I understand that:</i></p> <ul style="list-style-type: none"> ▪ My right to healthcare treatment is not conditioned on this authorization. ▪ I may cancel this authorization at any time by submitting a <u>written</u> request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization. ▪ If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed. ▪ Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization. ▪ There may be a charge for the requested records.

Signature of Patient _____ Date _____