UNT HEALTH PATIENT SERVICES

Health Information Management / Medical Records, 855 Montgomery Street, PCC 102, Fort Worth, TX 76107
Phone: (817) 735-2185 * Fax: (817) 735-0210 * E-Mail: medicalrecords@unthsc.edu

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

SSN: _____ Phone Number: _____

1. I authorize the disclosure of the above-named individual's health information as described below.

   Records to be released from (Include Address/Fax): _____

   _____

2. Range of treatment dates: _____

3. The type of information to be disclosed is as follows:

   ___ All clinical records ___ Laboratory reports ___ Pathology reports ___ Radiology reports

   ___ Other: _____

   _____

4. This information may be disclosed to and used by the following individual or organization:

   UNT Health Patient Services, Clinic: UNTHSC Geriatric Assesment and Planning Program (GAPP)

   Address: 855 Montgomery Street, Fort Worth TX 76107

   Phone: 817-735-2200 **Fax:** 817-735-5441

5. For the purpose of: **Continuing Medical Care**

6. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

7. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

8. I understand I have the right to revoke this authorization at any time. *I understand if I revoke this authorization, I must do so in writing and present my written revocation to UNT Health, Health Information Management, Medical Records, 855 Montgomery Street, PCC-102, Fort Worth, Texas 76107.* I understand the revocation will not apply to information that has already been released in response to this authorization. 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 in 180 days.** A photocopy of this document is to be given the same effect as the original document.

9. I understand that my disclosure authorization is not required for purposes of treatment, payment, healthcare operations, research programs, or for the release of testing results for pre-employment purposes.

10. I understand that I may be charged a fee for personal copies of my medical records in compliance with Texas Administrative Code, Title 22, Part 9, Chapter 165, Rule §165.2.

_____ _____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name Relationship to Patient