University Health System

AUTHORIZATION TO USE AND DISCLOSE PROTECTECTED HEALTH INFORMATION

Patient's Name: _____
LAST FIRST MIDDLE

Social Security Number: _____ Date of Birth: _____

Home Address: _____
STREET CITY STATE ZIP CODE

Home Phone:(___)_____ Cell/Work Telephone Number:(____)_____

I hereby authorize **University Health System** to disclose my Protected Health Information to the following Designee:

ExamOne

RECIPIENT: Name of person or class of persons to whom University Health System may disclose my Health Information:

Address of the recipient or where my health information should be delivered:

800 NW Chipman Rd. / Suite 5900 / POBox 2340 / Lee's Summit, MO 64063-1149

City State Zip Code Phone Number

DESCRIPTION OF THE PURPOSE FOR THE USE AND/OR DISCLOSURE: _____

Description of Items to be released: ***You must specify if you wish to receive copies which include the audit report or do not include the audit report.*** (Check all that apply)

____Entire Record	____Laboratory Reports	____Billing Records
____Emergency Center Treatment	____Radiology Reports	____Photographs
____Discharge Summary	____Pathology Reports	____OTHER (please specify): _____
____History and Physical	____Physician Orders	_____
____Operative Reports	____Progress Notes	
____Consultation Reports	____Nursing Notes	

Date of Treatment: _____ ____**With Audit Report** ____**Without Audit Report**

- I understand this authorization will expire on _____ or 180 days from the date of this signed authorization.
  Date
- I understand if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.
- 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 the Health Information Services Department. I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.
- I understand the information in my health records may include information relating to AIDS, HIV, psychiatric, behavioral or mental health services, and chemical or alcohol dependency. This authorization does not include psychotherapy notes.

_____ _____ _____
Patient Signature or Personal Representative | Description of Authority | Date

Form of Identification verified (Driver License/other picture ID:_____ Staff Initials:_____

University Health System, 4502 Medical Drive, Medical Records Department, MS26-2, San Antonio, TX 78229-4493
Phone number: (210)358-3532 Fax number: (210)358-5936