

**The University of Texas at Arlington Health Services
Medical Release Form – From Other Entities**

1. I hereby authorize _____ to use and disclose protected health information to UT Arlington Health Services (UTAHS) from the record(s) of:

Patient's Name: _____ Date of Birth: _____

UT Arlington ID No.: _____

2. **Release is for the purpose of (state specific reason):**

Information to be released (indicate dates and specific records required):

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

4. I understand that copies of the records indicated above will be: (check one or more, as applicable)

Sent to:

Name of Recipient: _____
UT Arlington Health Services
Box 19329
Arlington, TX 76019

Faxed to:

Name of Recipient: _____
UT Arlington Health Services
Fax Number: _____
Confirmation Telephone Number: _____

5. I understand that since the Recipient of this information, as identified above, is a "covered entity" under Federal or Texas privacy law, the information is protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, is not subject to re-disclosure by the Recipient.

6. I understand that the purpose(s) of the requested use and disclosure is (are):

At the request of the individual

Other: _____

7. I understand that I may revoke this authorization in writing at any time except to the extent that _____ has already relied on this authorization. I understand that I may revoke this authorization by mailing or faxing a written notice to _____ stating my intent to revoke this authorization.

8. Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is: 90 days from date of signature.

9. I understand that my completion of this authorization form may not be a condition of treatment.

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name of Legal Representative (if any): _____

Representative's Authority to Act for Patient: _____