



family wellness center

THE UNIVERSITY OF TEXAS AT AUSTIN SCHOOL OF NURSING

2901 N. IH 35, Ste 101 □ Austin, TX 78722
512-232-3900 • (fax) 512-471-1455

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the following protected health information to be released from the medical record of:

_____ Last Name (Please Print)	_____ First Name (Please Print)	_____ Date of Birth
_____ Address	_____ City/State	_____ Zip Code
_____ Phone Number (s)	_____ Date	

Purpose of Disclosure: <input type="checkbox"/> At the request of the individual. <input type="checkbox"/> Other (DESCRIBE REASON FOR DISCLOSURE) _____ Method of release: <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Pick-up

RELEASE RECORDS: <input type="checkbox"/> From <input type="checkbox"/> To	RELEASE RECORDS: <input type="checkbox"/> From <input type="checkbox"/> To
The University of Texas at Austin School of Nursing	
Family Wellness Center	
2901 N. IH 35, Ste 101, Austin TX 78722	
512-232-3900	
512-471-1455 fax	

I understand that to the extent any recipient of this information, as identified above, is not a “covered entity” under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to recipient and, therefore, may be subject to re-disclosure by the recipient.

TO BE RELEASED

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Growth charts
<input type="checkbox"/> Laboratory results	<input type="checkbox"/> Imaging reports	<input type="checkbox"/> Psychiatric Evals/Tests
<input type="checkbox"/> ER Records	<input type="checkbox"/> Immunizations	<input type="checkbox"/> All records
<input type="checkbox"/> EEG, EKG	<input type="checkbox"/> Pathology reports	<input type="checkbox"/> Other

I understand that:

- _____ This authorization is valid for six months unless I notify the FWC otherwise.
- _____ I may revoke authorization except to the extent that facility has taken action prior to receiving notice of revocation or authorization was obtained as condition of obtaining insurance coverage.
- _____ This information may contain, and I consent to, release of information including alcohol, drug, abuse, psychiatric and HIV testing information _____ (initials)

SIGNATURE OF PATIENT (OR IF LEGAL REPRESENTATIVE-STATE AUTHORITY TO ACT)

DATE

PRINT NAME



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