The University of Texas at Austin
School of Nursing

Children's Wellness Center
Family Wellness Center

Clear Form

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I do herby consent and authorize UT Wellness Center to ☐ ***release*** ☐ ***obtain*** (select one) medical records of:

Patient Name: _____ Date of Birth: _____/_____/_____
Address: _____
City, State and Zip Code: _____
Parent/Guardian Name: _____Phone Number: _____

This information is requested to be ☐ ***released*** ☐ ***obtained*** (select one) from:

Name of Person or Medical Facility: _____
Person or Practice Address: _____
City, State and Zip Code: _____
Phone Number: _____ Fax Number: _____

Please select (✓) all the specific records that apply to your request:

☐ All Medical Records
☐ History &Physical
☐ Lab results/Imaging
☐ Diagnostic Test Reports
☐ Immunizations
☐ Past/Present Medications
☐ Discharge Summary
☐ ER Documentation
☐ Outside Records
☐ Billing Information
☐ Other: _____
_____

Please select (✓) the options below to authorize the release of sensitive information:

☐ Mental Health
☐ Psychotherapy Notes
☐ HIV/AIDS/other infectious disease
☐ Drugs or Alcohol
☐ Genetic Testing

Please select (✓) the purpose this information is requested:

☐ Continuation of Care
☐ Patient Request
☐ Other: _____

This authorization will last for one year or until _____ (date or event).

By signing below, I agree:

- *I have read this form and agree UT Austin School of Nursing Wellness Center may release my information as set forth above. I may withdraw my permission at any time. If I withdraw my permission, my PHI will not be released again as set forth above. However, any disclosures already made based on this will not be affected. I may withdraw my permission by notifying UT Austin School of Nursing Wellness Center in writing.*
- *UT Austin School of Nursing Wellness Center will not require me to sign this form to be treated. I may request a copy of this signed form.*
- *I understand PHI disclosed pursuant to this Authorization may be subject to re-disclosure by the person or party it goes to and may no longer be protected by federal or state privacy laws.*

Signature of Patient or Representative: _____

Printed Name of Patient or Representative: _____

Relationship to Patient: _____ Date: _____

To the authorized party receiving this information: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFT, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.