THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER AT HOUSTON
SCHOOL of NURSING

UT Health Services

Request and Authorization for Medical Records

The patient indicated below has authorized us to release a copy of his/her medical records. Below is a signed authorization for release of information.

Your prompt reply in getting these records to our office will facilitate us providing the patient with continual care. Thank you for assisting us in this matter.

I hereby request and authorize that:

Name of clinic, doctor's office, hospital _____
Address _____
_____
City, State, Zip _____

convey to the University of Texas Health Service (UTHS) all medical information, unless otherwise noted, on my treatment at your facility. The question of privacy between you and you institution, my attending physicians, UTHS and myself is waived. This authority is extended to the furnishing of copies of all or any desired parts of this medical record.

Patient name:_____ SS#:_____
Patient DOB:_____

Patient signature_____ Date:_____

Witness:_____

Please send my records to:
University of Texas Health Services
7000 Fannin, Suite 1620
Houston, Texas 77030
Fax: 713-500-3263
Phone: 713-500-3267