UMC HEALTH SYSTEM

Service • Teamwork • Leadership

UNIVERSITY MEDICAL CENTER
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

IDENTITY OF PATIENT

Patient Name: _____
Address: _____
Account #: _____ Date of Birth: _____

WHO MAY MAKE THE DISCLOSURE

I request and authorize the following entity and its employees and agents to release information relating to the diagnosis, care, and treatment of the above-named patient:

University Medical Center, 602 Indiana Avenue, Lubbock, TX 79415.

TO WHOM THE DISCLOSURE MAY BE MADE

Name: LUBBOCK PRIVATE DEFENDERS OFFICE
Address: 1401 CRICKETS AVE. (MAIN) 806-749-0007
LUBBOCK TX 79401 (FAX) 806-749-0007

WHAT INFORMATION TO DISCLOSE

The type and amount of information to be used or disclosed is as follows (check off the appropriate item(s), and include other information, where indicated):

[✓] All medical records
[ ] Medical records from _____ (date) to _____(date)
[✓] Other (specify) ALL MENTAL HEALTH AND/OR PSYCHIATRIC AND/OR SUBSTANCE ABUSE RECORDS/TREATMENT

I understand that information in my health record may include information relating to: (1) AIDS/HIV test results, infection status, or treatment information; (2) sexually transmitted disease; (3) treatment for alcohol and drug abuse; and (4) behavioral and mental health services. I AUTHORIZE THE DISCLOSURE OF THIS INFORMATION EXCEPT AS FOLLOWS:_____.

PURPOSE OF DISCLOSURE

This information is being released for the following purpose(s):

[ ] Continued care by other health care provider
[✓] Attorney
[ ] Insurance
[ ] School
[ ] Other (specify) _____
[ ] Personal review

TERMS OF DISCLOSURE

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Records Custodian, Health Information Management, University Medical Center, 602 Indiana Avenue, Lubbock, TX 79415. I understand that the revocation will not apply to information that has already been released in response to this information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: 1 YEAR FROM DATE OF SIGNATURE

If I fail to specify an expiration date, event, or condition, this authorization will expire 180 days from the date of signing.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that I need not sign this order to ensure health care treatment.

I fully understand and accept the terms of this authorization.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Name of Representative (if applicable) Relationship to Patient

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For Office Use Only
[ ] Authorization verified by _____ on _____
[ ] Patient has been provided with a copy of the signed authorization.