To be in compliance with the new Health Insurance Portability and Accountability Act (HIPAA), there are ten elements that must be included on an authorization form for it to be valid. The authorization form you provided is missing one or more of these elements (see below). To assist in expediting your request, The University of Texas Medical Branch (UTMB) prefers that you have your client/our patient complete and sign the UTMB Authorization form. A copy of the form is attached. Please reproduce the form as needed. The form may also be obtained from the UTMB website, www.utmb.edu/compliance/hipaa.

If you choose to provide your authorization form it must include **all** required elements. A valid authorization must contain at least the following elements and must be written in plain language and legible:

1. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion. **(Billing Records/Itemized Billing)**

2. The name or other specific identification of the person or class of persons, authorized to make the requested use of disclosure. **(UTMB)**

3. The name or other specific identification of the person or class of persons, to whom UTMB may make the requested use or disclosure.

4. Description of each purpose of the requested use and disclosure. The statement "at the request of the individual" is sufficient description when an individual initiates the authorization and does not, or elects not to, provide a statement of purpose.

5. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study", "none", or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.

6. Signature of the individual and the date

7. If a personal representative of the individual signs the authorization, a description of individual's authority to act for the individual.

8. A statement of the individual's right to revoke the authorization in writing and the exceptions to the right to revoke, together with a description of how the individual may revoke the authorization.

9. The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization

10. A statement that the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA Privacy Regulations

UH Number: _____

UTMB USE ONLY: Please check one: _____ HIM to release PHI _____ PHI already has been released; HIM to only file Authorization

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) By UTMB

Patient Name: _____ _____

Last First M.I. (Previous Or Other Names Used)

Address: _____

Date of Birth: _____ **UH Number:** _____

If this Authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

_____

I authorize the release of medical records from: University of Texas Medical Branch- Health Information Management

301 University Blvd. Galveston, Texas 77555-0782

Telephone Number : (409) 772-1965 Fax Number: (409) 772-5101

Please release requested medical records to: Name: _____

Address: _____

City: _____ State _____ ZIP _____

Telephone Number: _____ Fax Number: _____

I specifically authorize the use and disclosure of the following PHI: **(Please provide a detailed description of the particular data and period of time you are requesting)**

□ Emergency Records	_____	□ Hospital Records	_____
□ Clinic Records	_____	□ Radiology Reports	_____
□ Lab Reports	_____	□ Radiology Films	_____
□ Shot Records	_____	□ Pathology Reports	_____
□ Slides	_____	□ Pharmacy Reports	_____
□ Other	_____		_____

This authorization will expire on the 180th day of the signing or as otherwise specified below:

_____

By signing this Authorization Form, I understand that I am giving my authorization for UTMB to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying UTMB in writing to the Health Information Management Department, 301 University Blvd, Galveston, Texas 77555-0782 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by UTMB before UTMB received my written notice of revocation. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from UTMB.

_____ _____

Signature of Patient or Authorized Personal Representative **Date**

_____

Relationship to the Patient (If signed by a Personal Representative)

IF PATIENT ID CARD IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) BY UTMB

Medical Record Form 7032-Rev. 8/03

The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM.