



HIM Department Telephone #: 940-320-8047

HIM Department Fax #: 940-320-8030

I authorize the University Behavioral Health of Denton (UBH) to **release/obtain** (circle one) medical information concerning:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Dates of Service \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone Number \_\_\_\_\_

**This information is to be released to/obtained from** (circle one):

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_

*Please check and initial the boxes below for the type of Treatment Information you are Authorizing UBH Denton to release to the requesting parties:*

**Please release the following information, indicated by an "X":**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation        | <input type="checkbox"/> Assessment     |
| <input type="checkbox"/> Lab Results        | <input type="checkbox"/> Radiology Results   | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Billing Records    | <input type="checkbox"/> Psychotherapy Notes | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Medications         | <input type="checkbox"/> Other _____    |

**INITIAL**

<b>HIV</b> _____	_____
<b>Medical</b> _____	_____
<b>Psychiatric</b> _____	_____
<b>Substance Abuse</b> _____	_____

**This information is necessary for the following purposes:**

\_\_\_ Follow-up Care \_\_\_ Patient is requesting disclosure \_\_\_ Disability Benefits \_\_\_ Attorney or Legal  
\_\_\_ Other Please Explain \_\_\_\_\_

Please release my information via: \_\_\_ Mail

**The patient or the patient's representative must read the following statements:**

*I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall expire in six (6) months from when it is signed unless otherwise specified (Otherwise specified date \_\_\_\_\_). I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon expiration, the University Behavioral Health Denton (UBH) can no longer use or disclose my information for the above purposes without a new authorization.*

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information.

*I understand any of the above requested information may include results of sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders.*

**TO THE 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 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

\_\_\_\_\_  
SIGNATURE of Patient or Authorized Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
RELATIONSHIP to Patient

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
REASON Patient is Not Signing

**CC0908**  
**Rev: 8/1/2018**

Patient Label