



UBH of Denton AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Health Information Management Contact Information

Telephone: # 940-320-8047 Fax: # 940-320-8030 Email: UBHDENTONROI@uhsinc.com

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Maiden/Prior Names: \_\_\_\_\_ Current Phone #: \_\_\_\_\_

Current Address: \_\_\_\_\_ Last 4 of SS#: \_\_\_\_\_

\*\*\*All sections above and below must be filled out to be considered valid

To be released to or requested from:  Self (address above)

\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_
Name of Person/Agency/Organization Telephone Number Fax Number Email

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Address City State Zip Code Name / Attention to (if applicable)

Release information/records via:  Mail  Fax  Pick-up  Email: \_\_\_\_\_
 Verbal Exchange of Information ONLY

I am requesting disclosure of my protected health information for the following purpose:

- Continuing Care  Disability Determination  Child Custody  Personal Use
 Academic  Legal Investigation  Billing/Insurance  Other: \_\_\_\_\_

Dates of Service Requested: \_\_\_\_\_
(if unsure of exact dates put a specific time range ex. June 2025 – July 2025 or if needing all records put all 'all dates of services')

I authorize the release of the following information including all records that include any substance use disorder and/or substance use disorder treatment records, or

I authorize the release of the following information excluding all records that include any substance use disorder and/or substance use disorder treatment records, or

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

- Discharge Safety/Planning – verbal only  Discharge Summary  Billing Records
 Continuity/Transition of Care Packet  Progress Notes  HIV Test Results and AIDS Treatment Records
 Psychiatric Evaluation  Physician Orders  Other: \_\_\_\_\_
 History and Physical  Medications / MAR  Other: \_\_\_\_\_

This authorization will expire on \_\_\_/\_\_\_/20\_\_\_. (If not indicated, authorization will expire one year from signature date)

This form must be completed in full before signing: \*\*The authorizing signature must be a 'wet signature' and cannot be electronic.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Patient's signature (required for 18 ages and older) Date/Time Parent/Legal Guardian signature (if applicable) Date/Time

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Witness signature/Credentials Date/Time Signed Relationship to Patient

This authorization is intended to allow University Behavioral Health of Denton to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Revocation Signature Date/Time Witness signature/Credentials Date/Time