UTHealth | Medical School
The University of Texas
Health Science Center at Houston

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ _____
Last First M.I. (Previous or Other Names Used)

Address: _____

_____

Date of Birth: _____ *Social Security Number: _____
(**Only last four digits of SS#**)

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: _____

_____

_____

Please release requested medical records to:

Name: Dr. K. Lance Gould, Dr. Stefano Sdringola, Dr. Nils Johnson, and Dr. Monica Patel

Address: 6431 Fannin St. MSB 4.256 Houston, TX 77030

Phone Number: 713-500-5200 Fax: **713-704-2695**

I specifically authorize the use and disclosure of the following PHI:

- Heart Related Clinical Records _____
- SPECT/ Nuclear Test Results _____
- Lab Reports Lipid and metabolic panel_____
- Other _____

This authorization will expire on the 180th day of the signing unless a lesser date is specified:

_____

By signing this Authorization Form, I understand that I am giving my authorization to UT Health/The University of Texas Health and Science Center at Houston Medical School (UTMS) 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. I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient. I understand that I may revoke this authorization in writing at any time except to the extent that UTMS has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to 6431 Fannin St, MSB 4.256 Houston, Texas 77030 or fax 713-704-2695. 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 UTMS.

_____ _____
Signature of Patient or Authorized Personal Representative Date

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