UT Physicians
A Part of UTHealth

UNIVERSAL AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(To request medical records from an outside provider for incoming medical record use)

1. I hereby authorize Siddharth Prakash, MD, PhD or Michelle Rivera, MD (name of physician, health care facility)
UT Physicians Turner Syndrome Adult Comprehensive Care Center (address: city, state, zip)
6410 Fannin Street, Suite 600, Houston, Texas 77030 832-325-7365 713-383-1467 (phone number, fax number)
to use and disclose protected health information from the record(s) of:

Patient's Name (Print):_____ Birth date: _____ MRN:_____

2. Copies of the following records shall be used and disclosed:
   - [X] Complete Clinical Records; or
   - [ ] Other (specifically identify exact information to be disclosed, including dates of service)

History and physical exam	Laboratory test reports	Photographs, videos, etc._
Consultation reports	Discharge Summary_	Physical Therapy Notes_
X-ray reports	Progress Notes_	Other

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental and behavioral health or psychiatric care.

4. I understand that copies of the records indicated above will be submitted to **UT Physicians**: (check one or more, as applicable)

   [ ] Send records to: **UT Physicians**
   Department Address:_____
   City:_____ State:_____ Zip Code:_____
   Name of Department/Recipient:_____

   [X] Fax records to: **UT Physicians** Attn: TSACCC
   Fax Number: 713-383-1467
   Confirmation Telephone Number: 832-325-7365
   Name of Department/Recipient: Internal Medicine

   [ ] Make available to: Name of Recipient: _____
   Confirmation Telephone Number: _____

5. 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.

6. I understand that the purpose(s) of the requested use and disclosure is (are): medical treatment

7. I understand that I may revoke this authorization in writing at any time except to the extent that UT Physicians (name of physician, facility) has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to UT Physicians (name of physician, facility, etc. & address).

8. Unless otherwise revoked, this authorization will expire on the 180th day of the signing or as otherwise specified below:_____.

9. I understand that Dr. Prakash or Dr. Rivera (name of physician, facility) may not condition treatment on my completion of this authorization form.

Signature of Patient or Patient's Legal Representative:_____ Date_____
Printed Name of Legal Representative (if any):_____
Representative's Authority to Act for Patient: _____
[UT Physicians Medical Records Telephone: 832-325-6543, Fax: 713-512-2250]