UT Physicians
A Part of UTHealth

Legal Billing Records

(For Personal Injury Cases)

Affidavit & Subpoena Dept., 6410 Fannin, 1500, Houston, Texas 77030
832-325-7711

HIPAA AUTHORIZATION

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Required by Federal Law)
(FOR UT Physicians PATIENTS TO REQUEST BILLING RECORDS)

1. I hereby authorize UT Physicians to use and disclose protected health information from the record(s) of:

   Patient's Name (Print): ____________________
   Birth date: ____________________ Social Security Number: ____________________
   MRN (Medical Record Number): ____________________

2. Copies of the following records shall be used and disclosed:
   ____ Complete Billing Records; or
   ____ Other (specifically identify exact dates of service) ____________________

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 or behavioral health or psychiatric care.

4. I understand that copies of the records indicated above will be: (check as applicable) _____ Sent to:

   Name of Recipient: ____________________
   Name of Company: ____________________
   Address: ____________________
   City__________ State: __________ Zip Code: __________
   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):
   ____

7. I understand that I may revoke this authorization in writing at any time except to the extent that UT Physicians has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to 6410 Fannin, Suite 1500 Houston, Texas 77030, 713-512-2219 fax.

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

9. I understand that UT Physicians 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: ____________________

A patient or his/her legal representative may request a copy of his/her billing record, or for a copy to be sent to another party, by completing a Release of Information form (Authorization for Use and Disclosure of Protected Health Information).

Completion of this form allows UT Physicians to transfer the billing records in compliance with the requirements for protection of patient health care information (HIPAA).

There is an allowable charge for duplication and transfer of a billing record.

Contact 832-325-7711 for instructions on mailing your billing record request & pre-payment.

In compliance with OCCUPATIONS CODE TITLE 3 CHAPTER 159 Sec. 159.008 TEXAS ADMINISTRATIVE CODETITLE 22 EXAMINING BOARDS PART9 TEXAS MEDICAL BOARD CHAPTER 165 MEDICAL RECORDS RULE § 165.2 MEDICAL RECORD RELEASE AND CHARGES.