UT HEALTH SERVICES
EMPLOYEE HEALTH SERVICES
7000 FANNIN STREET, SUTE 1620
HOUSTON, TX 77030

713.500.3267
713.500.3263 FAX

Request and Authorization for Medical Records

The patient indicated below has authorized us to request a copy of the following medical records:

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Below is a signed authorization for release of information.

Your prompt reply in getting these records to our office will facilitate us providing the patient with continual care. Thank you for assisting us in this matter.

I hereby request and authorize that: ______________________

Name of Clinic, Doctor's Office, or Hospital: ______________________

Address ______________________

City, State, Zip ______________________

Phone: ______________________ Fax: ______________________

convey to The University of Texas Health Service (UTHS) all medical information, unless otherwise noted, on my treatment at your facility. The question of privacy between you and your institution, my attendintg physicians, UTHS and myself is waived. This authority is extended to the furnishing of copies of all or any desired parts of the medical record.

Patient name: ______________________

Patient DOB: ______________________

Patient Signature: ______________________

Please send my records to:

University of Texas Health Services

7000 Fannin, Suite 1620

Houston, TX 77030