

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:

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: Fa:	x:
convey to The University of Texas Health Service (UTHS) all n	
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	