Urgent Behavioral Health Care
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San Antonio, Texas 78215
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Patient Authorization for Release of Health Records to External Parties

1. I authorize Urgent Behavioral Health Care (UBHC) to disclose information from the health records of

   First Name:_____Last Name:_____

   Date of Birth: _____ SSN#:_____

2. The information is to be disclosed to/from:

   Name: _____ Name: _____

   Address: _____ Address: _____

   _____ _____

   Phn/Fax: _____ Phn/Fax: _____

   I authorize this information to be disclosed in the following ways:

   ❑ Written/Photocopy/Paper ❑ Electronic Format ❑ Verbal ❑ Fax ❑ Electronic Mail

   Purpose of the disclosure: ___Coordination of Care ___ Assistance/Support of Trmt
   ___ Other _____

3. Dates of Treatment: From: _____ To: _____

   Specific reports to be disclosed:

   ❑ Progress Notes
   ❑ Discharge Summary
   ❑ Laboratory Reports
   ❑ Radiology Reports
   ❑ Photographs/Videotapes
   ❑ Records from other facilities

   ❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
   ❑ Other (Specify):_____

   I give specific authorization to disclose the following information:

   ❑ HIV test results
   ❑ Drug and alcohol abuse treatment records
   ❑ Documentation of AIDS diagnosis
   ❑ Psychiatric/Mental Health treatment records

   I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However,

any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying UBHC in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization expires in one year or: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____

Signature of Patient (or Patient Representative) Date

Printed name is acceptable if you don't know how to add a digital signature.

_____ _____

Printed Name of Patient or Patient Representative (Relationship to Patient)

***** Need to ensure separate E-mail Authorization Agreement is signed.
Note: Release of Psychotherapy notes requires a separate authorization.

Email Form

*If the email form button does not work on your system please manually attached the pdf files and email to UBHC@UrgentBehavioralHealthCare.com.