



Authorization for Release of Prescription Records

DATE

I authorize the following protected health information to be released from the prescription record of:

LAST NAME (PLEASE PRINT)

FIRST NAME (PLEASE PRINT)

DATE OF BIRTH

EMAIL ADDRESS

UTEID

PHONE NUMBER

FAX NUMBER of Requestor

Requested Date(s) of prescription profile:

NOTE: If specific dates to be released are not indicated, all records will be released.

Release Records From:

UHS Pharmacy
P.O. Box 7339
Austin, TX 78713-7339
Fax 512-475-8218

Release Records To:

If same as above

OR:

NAME / ORGANIZATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

Please call when my records are ready for pick-up

Please fax my records to _____.

SIGNATURE OF PATIENT (OF IF LEGAL REPRESENTATIVE –STATE AUTHORITY TO ACT)

DATE

**** Please fax completed form along with a copy of your photo ID to 512-475-8218 ****