



THE UNIVERSITY of TEXAS

HEALTH SCIENCE CENTER AT HOUSTON

Patient's Name: _____

Birth date: _____

Authorization for the Use and Disclosure of Protected Health Information (HIPAA Release Form)

The next of kin of the deceased _____ request and direct to release the decedent's medical records to the Department of Pathology and Laboratory Medicine at the University of Texas Medical School at Houston.

This authorization permits the above provider to disclose the following clinical records:

- _____ All of the decedent's clinical records that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me; or
- _____ All of the decedent's health care information described above except for the following.
_____ (specifically identify)
- _____ Only the following records or types of records (insert dates of treatment, type of treatment or other designation)

The next of kin 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.

The next of kin understand that copies of the records indicated above will be: (check one or more, as applicable)

_____ Sent to: Name of Recipient: _____
 Name of Company: _____
 Address: _____
 State: _____ Zip Code: _____

_____ Faxed to: Name of Recipient: _____
 Name of Company: _____
 Fax Number: _____
 Confirmation Telephone Number: _____

_____ Made available to: Name of Recipient: _____
 Confirmation Telephone Number: _____

The next of Kin 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. The next of kin understand that the purpose(s) of the requested use and disclosure is to investigate more fully the central nervous system and possible reasons for this patient's dementia.

The next of kin understand that the next of kin may revoke this authorization in writing at any time except to the extent that the covered entity has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to the UT Outreach lab at 6431 Fannin St, MSB 2.008, Houston, TX 77030, Phone 713 500-5258 Fax 713 500-0783 stating my/our intent to revoke this authorization.

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

Signature of Decedent's Next of Kin: _____ Date: _____

Printed Name of Decedent's Next of Kin _____