



PATIENT RELEASE FORM

- (a) I authorize the health care professionals who treat me through UT Health San Antonio to discuss any and all patient information about me and my treatment, medical condition or related topics to visiting clinicians, healthcare professionals, and care-related vendors.
- (b) I release UT Health San Antonio from any and all state or federal statutes relating to patient privacy.
- (c) I specifically authorize officials from UT Health San Antonio to discuss my case (or my child's case, or an individual to whom I provide guardianship), with these individuals.
- (d) Any release of original or copies of records will require my written authorization.

Date of Observation: _____

Affiliated individual (Choose One): Visiting Clinicians Healthcare Professionals
 Care-related Vendors

Name (Please Print): _____

Signature: _____

Parent/Guardian Signature for (Please Print): _____

Date: _____

Telephone number: _____