LAUREL RIDGE
TREATMENT CENTER
17720 Corporate Woods Drive, San Antonio, Texas 78259
Phone: (210) 491-9400 | Fax: (210) 319-4243 | LAURELRIDGEMedicalRecordsMailbox@uhsinc.com

Dear Requestor,

Laurel Ridge Treatment Center takes its obligation to protect the privacy of its patients' information very seriously. As a health care provider, we are entrusted with some of our patients most sensitive health information. For that reason, we take steps, over and above what the law may require, to protect the privacy of our patients' information.

If you are seeking a patient's medical records, a valid written authorization executed by the patient or their legal personal representative is required. If you do not already have one, please complete the attached form in full, including the dates of service requested and all required selections. All authorizations must include either a **wet signature** or a valid **electronic signature** (e.g., DocuSign or AdobeSign). Once completed, please submit the authorization along with a **valid photo ID** by one of the following methods:

- **Email:** LAURELRIDGEMedicalRecordsMailbox@uhsinc.com
- **Fax:** (210) 319-4243

Additional Requirements:

- **Minor Records:** Include a copy of the parent or legal guardian's ID. If a parent's or guardian's right to access their child's records has been legally restricted, provide that documentation with the authorization.
- **Caseworkers / Government Personnel:** Include a copy of your official ID (badge) or supporting documentation (e.g., letter, email, or court order).
- **Personal Representatives**. Include a copy of the documentation that demonstrates your legal authority to act as the Personal Representative for the patient.
- **Substance Use Treatment Records:** Per **42 CFR Part 2**, if the patient is old enough to provide consent for their own substance use disorder treatment under state law, the patient must sign the authorization, even if the patient is a minor.

Requests will be processed once a complete authorization and valid ID are received. In accordance with **Texas Administrative Code §163.3 and the Texas Medical Practice Act**, please allow up to **15 business days** for completion. If you have questions or need assistance, please contact the HIM Department at **210-339-3004** or via email.

Sincerely,

The Health Information Management Department

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PATIENT AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth	Date of Service

I hereby freely and voluntarily authorize Laurel Ridge Treatment Center to (Check Applicable Boxes):

- ☐ **Release/Disclose records of my health information to:**
- ☐ **Obtain records of my health information from:**

(Individual, Facility, Organization) (Telephone Number)

(Address) (Fax Number)

(City, State, Zip) (Email)

The purpose for this disclosure is: _____

The information to be released includes:

- ☐ Complete Record
- ☐ Admission Psychiatric Evaluation
- ☐ History and Physical
- ☐ Psychological Testing
- ☐ Treatment Plans
- ☐ Discharge Summary
- ☐ Verbal exchange of information
- ☐ Other

My medical records may include information regarding testing, diagnosis and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, tuberculosis, and other communicable diseases. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law.

I understand that I have the right to revoke this authorization at any time by giving written notice to the Laurel Ridge Treatment Center Privacy Officer, except to the extent that Laurel Ridge Treatment Center has already taken action in reliance on it. This authorization will expire in **180 days** or as otherwise specified herein: _____; whichever comes first.

Patient Signature *Patient must sign release regardless of age if alcohol and/or drug treatment is involved.* Date

Parent/Guardian/If Authorized Representative (Describe: _____) Date

Witness Signature Date