UTSouthwestern Medical Center

Authorization to Disclose Protected Health Information

Patient Name: _____

Other Names Used: _____

Address: _____

_____
City State Zip

DOB: _____ Phone Number: _____

Email Address: _____

Return form to:
Health Information Management – Release of Information
5323 Harry Hines Boulevard
Mail Code 8525
Dallas, Texas 75390-8525

Fax: 214-645-9141
E-mail: Medical.Records@UTSouthwestern.edu

Patient Notice – Please complete this form in its entirety.

A. I understand that the information is to be released for the following purpose: **(Check all that apply)**
☐ Personal ☐ Continuity of Care ☐ Insurance/Billing ☐ Disability ☐ Legal
☐ Other: _____

B. I understand the information requested will be released to the following: **(Check one)**
☐ Self
☐ Requestor Name/Facility Name _____ Attn: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax : _____ Email: _____

C. Records will be delivered by an electronic transfer for the fastest delivery *(Ex. MyChart, Secure File Portal or E-mail, Life Image).*
If another delivery method is preferred, please specify (*Ex. CD/DVD*)_____

D. Information to be released: *Abbreviations used - History and Physical (H&P); Discharge Summary (DS); Procedure/Operative Report (OP); Physical Therapy (PT); Occupational Therapy (OT); Speech Therapy (ST); Electronic Health Information (EHI).*

☐ Abstract Hospital
(H&P, DS, OP, Consult, progress notes, diagnostic reports)
☐ Abstract Clinic
(OP, progress notes, diagnostic reports)
☐ Provider Reports
(H&P, DS, OP, Consult, progress notes)
☐ Therapy Notes *(PT, OT, ST)*
☐ Discharge Summary *(DS)*
☐ Procedure/Operative Report *(OP)*
☐ Cardiac Cath Report
☐ Pathology Report
☐ Labs
☐ Immunizations
☐ Itemized Billing Statement
☐ EHI Export File *(machine readable format only)*

☐ Radiology Results: _____
❍ Reports Only ❍ Images Only ❍ Reports and Images Only
☐ Genetics: _____
☐ Psychiatry/Behavioral Health: _____
☐ Research: _____
☐ Student Health: _____
☐ Radiation/Oncology: _____
☐ Home Health: _____
☐ Dental Images: _____
☐ Employee Assistance Program (EAP): _____
☐ Specific Doctor/Location: _____
☐ Other: _____
_____
_____
_____

E. Date range of information to be released: ☐ Last 2 years or ☐ From: _____ To: _____
(Month/Year) (Month/Year)

- I hereby authorize UT Southwestern Medical Center to disclose my protected health information (PHI). A valid government-issued photo ID will be required for patient privacy and confidentiality purposes. I understand a processing and shipping fee may apply.
- I understand that the record provided may be incomplete and additional documentation will continue to be added throughout the course of my stay. I understand that I may request a complete copy at approximately 30 days post discharge.
- UT Southwestern will not condition treatment, payment, enrollment or eligibility for benefits based on the completion of this form.
- This specific authorization form does not authorize the release of Substance Abuse Therapy Records. A separate "Authorization to Disclose Substance Abuse Therapy Record" must be completed. I understand that the records used and disclosed pursuant to this authorization may include information relating to: Genetic counseling; Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) treatment; history of drug or alcohol abuse; mental, behavioral health, or psychiatric care; and/or other sensitive information.
- I understand that I may revoke this authorization in writing at any time, except to the extent that UT Southwestern has relied on this authorization. The written revocation should be addressed to the Release of Information Department. Unless otherwise revoked, I understand that the date or event upon which this authorization expires is 180 days from the date of signature. A photostatic copy of this authorization is considered as valid as the original.
- I understand to the extent that any recipient of this information, as identified above, is not a "covered entity" under the Federal or Texas privacy laws, 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.
- I understand that according to Chapter 159 of the Texas Occupational Code Section 159.005 (e) and HIPAA, a re-disclosure could be made from records received from another health care provider involved in my care or treatment.

_____ _____ _____
Patient's Printed Name Patient's Signature Date

_____ _____ _____
*Legal Representative's Printed Name Legal Representative's Signature Date

_____
If representative, please specify relationship to patient.

***Note**: Proof of legal authority will be required for legal representatives.