UT Southwestern
Medical Center

Authorization to Disclose Protected Health Information

Patient Name:_____

Other Names Used:_____

Address:_____

_____
City State Zip

DOB: _____ Phone Number: _____

Email Address: _____

Instructions: Complete all applicable sections to have information disclosed from UT Southwestern Medical Center to another provider or requestor. UT Southwestern will not condition treatment, payment, enrollment or eligibility for benefits based on the completion of this form.

Return form to:
Health Information Management – Release of Information
Fax: 214-645-9141
Email: medical.records@utsouthwestern.edu
Ph: 214-645-3030, option 1, option 1

Mailing Address:
Health Information Management – Release of Information
5323 Harry Hines Boulevard
Mail Code 8525
Dallas, Texas 75390-8525

Patient Notice – This Section Applies to All Requests

Note: This is a required section and must be completed in its entirety. Records requested are in electronic format (e.g. CD) unless requested in paper. Currently, electronic signatures are not accepted.

I hereby authorize UT Southwestern Medical Center to disclose my protected health information. Identification will be required for patient privacy and confidentiality. **I understand a processing and shipping fee may apply for the requested information.**

A. I understand that the information is to be released for the following purpose: **(Check all that apply)**

◯ Attorney/Legal ◯ Healthcare ◯ Patient Record ◯ Self-Pay Financial Account Balance (MyChart)
◯ Billing or Claims ◯ Insurance ◯ Review Request ◯ Other _____
◯ Disability ◯ Military ◯ School

B. I understand the information requested will be released to:

Name/Facility Name:_____

Attn:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____ Fax:_____

C. Check requested delivery method: ◯ Email Portal ◯ MyChart* (patient only) ◯ Pick-Up Records
Note: Costs may vary by selection ◯ Fax ◯ Postal Mail ◯ Other _____

Section 1 - Information to be Released – Check All Boxes That Apply

A. Information to be released: **(Check all that apply)**

◯ Billing Records ◯ Discharge Summary ◯ Home Health ◯ Office Visit Notes
◯ Blood Type ◯ Emergency Department ◯ Hospital Progress Notes ◯ Operative Records
◯ Complete Medical Record ◯ Explanted Materials, Devices or Hardware ◯ Immunization ◯ Pathology Blocks
◯ Consultation Reports ◯ Laboratory Reports ◯ Pathology Slides
◯ Dental Molds ◯ Face Sheet ◯ Medication Sheets ◯ Pathology Reports
◯ Dental Reports ◯ History & Physical ◯ MyChart Messages ◯ Radiation Records
◯ Other _____

B. Time period or date of information to be released: From:_____ (Month / Year) To:_____ (Month / Year)

C. ◯ Specific Physician(s): _____ ◯ or All treating physicians

D. ◯ Clinic/Hospital Name(s): _____

Note: 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.

White – Health Information Management Department Yellow – Patient

Form # 7680-001 / 01.05 (Rev. 01/17)

UT Southwestern Medical Center

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Other Names Used:_____

Address:_____

_____
City State Zip

DOB: _____ Phone Number: _____

Email Address: _____

Section 2 - Imaging/Radiology Record

A. Information to be released: **(Check all that apply)**

◯ Bone Density ◯ Dental Images ◯ MRI ◯ PET ◯ Xray
◯ Cardiac Catheterization ◯ EKG/ECHO ◯ Nuclear Medicine Scan ◯ Sonogram ◯ Other _____
◯ CT / CAT Scan ◯ Mammograms ◯ Ophthalmology Images ◯ Ultrasound

B. ◯ Images & Reports ◯ Reports Only ◯ Images Only

C. Time period or date of information to be released: From:_____ (Month / Year) To:_____ (Month / Year)

D. Ordering Physician (if known): _____

E. Check appropriate delivery method: ◯ Email Portal ◯ LifeImage Portal ◯ Pick-Up ◯ Postal Mail

Section 3 - Genetics, Psychiatry and Research Record

A. ◯ Genetics Records ◯ Complete Medical Record ◯ Other _____

Date(s) of information to be released: From: _____ (Month / Year) To: _____ (Month / Year) Physician Name (if known): _____

B. ◯ Psychiatry Records ◯ Complete Medical Record ◯ Other _____

Date(s) of information to be released: From: _____ (Month / Year) To: _____ (Month / Year) Physician Name (if known): _____

C. ◯ Research Records ◯ Complete Medical Record ◯ Other _____

Date(s) of information to be released: From: _____ (Month / Year) To: _____ (Month / Year) Physician Name (if known): _____

Section 4 – Student Health Record

A. Information to be released: **(Check all that apply)**

◯ Complete Medical Record ◯ Immunization ◯ Itemized Billing Record ◯ Student Wellness and Counseling Record

B. Time period or date of information to be released: From:_____ (Month / Year) To:_____ (Month / Year)

C. Physician Name (if known): _____

Patient Acknowledgement – This Section Applies to All Requests

- 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 that to the extent 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, specify relationship to the patient

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

Release of Information Use Only: Date Authorization Revoked, if applicable _____

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