





UNIVERSITY HOSPITALS & CLINICS  
University Clinics

**Patient's Request for Release of Information:  
Authorization for Verbal Release of  
Protected Health Information to  
Designated Persons**

UT Southwestern Medical Center  
1501 Marilee Dr  
Dallas, TX 75390-8864  
Tel: 214.645.3000  
Fax: 214.645.3000

**AT THE PATIENT'S REQUEST, THIS AUTHORIZATION GRANTS PERMISSION TO UT SOUTHWESTERN MEDICAL CENTER TO COMMUNICATE IN PERSON OR BY TELEPHONE WITH THE FOLLOWING PERSONS, DESIGNATED BY THE PATIENT, TO ASSIST WITH THE PATIENT'S HEALTH SERVICES. THIS AUTHORIZATION IS APPLICABLE FOR VERBAL INFORMATION ONLY AND IS NOT VALID FOR THE RELEASE OF THE WRITTEN MEDICAL RECORD.**

**I AUTHORIZE** UT Southwestern Medical Center to communicate my health information to the person(s) listed below ("Designated Persons") for the following purposes: to orally confirm my appointments; to discuss results of my X-ray, laboratory or other test results; to pick up sample medications or written prescriptions for me; to discuss my health care, diagnosis, prognosis, and treatment plans; and to discuss billing and payment for medical services provided by UT Southwestern Medical Center.

Please print the following information for each Designated Person:

Name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_  
Alternate Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_  
Alternate Telephone: \_\_\_\_\_

**I UNDERSTAND** that this authorization applies to all departments, healthcare providers and/or employees at UT Southwestern Medical Center.

**I UNDERSTAND** that this authorization is voluntary.

**I UNDERSTAND** that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

**I UNDERSTAND** that this authorization will be effective for my lifetime, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time by sending a written statement of revocation to:

UT Southwestern Medical Center  
Release of Information Department  
5323 Harry Hines Blvd.  
Dallas, TX, 75390-8864

If I revoke the authorization, it will not have any effect on any actions taken by UT Southwestern Medical Center prior to the processing of the revocation.

**I UNDERSTAND** that my refusal to sign this authorization will not negatively affect my health care services at UT Southwestern Medical Center.

COMPLIANCE