

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER
AT DALLAS
Ambulatory Services
**Authorization to Send
Protected Health Information**

Departments of Radiology

- ◆ Aston Radiology
- ◆ Positron Emission Tomography Facility (PET)
- ◆ Rogers Magnetic Resonance Imaging Center (MRI)
- ◆ UT Southwestern Center for Breast Care

SECTION 1

Request Date: _____
Patient Name: Last _____ First: _____ Middle: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Medical Record Number: _____ Social Security Number: _____
Telephone Number: _____ Date of Birth: _____

SECTION 2

A I hereby authorize the below **UT Southwestern Medical Center at Dallas or UT Southwestern Health Systems** entity to use and disclose the radiology section of my medical record. I understand I will be charged a retrieval/processing fee for copies. Identification will be required for patient privacy and confidentiality.

(Fill in all that apply)

- UT Southwestern Medical Center at Dallas-Aston Radiology
- UT Southwestern Medical Center at Dallas-Positron Emission Tomography Facility (PET)
- UT Southwestern Medical Center at Dallas-Rogers Magnetic Resonance Imaging Center (MRI)
- UT Southwestern Medical Center at Dallas-Simmons Breast Center
- UT Southwestern Medical Center at Dallas-Oral Surgery

B. I would like: *originals of the following copies of the following:

Note: originals must be returned to the radiology department within 30 days of check out.

(Fill in all that apply)

- | | |
|--|--|
| <input type="checkbox"/> X-ray/Images/Reports | <input type="checkbox"/> MRI Images/Reports |
| <input type="checkbox"/> Dental Images/Reports | <input type="checkbox"/> PET Images/Reports |
| <input type="checkbox"/> Mammograms/Sonograms/Reports | <input type="checkbox"/> Sonograms/Ultrasounds/Reports |
| <input type="checkbox"/> Medical Records (separate authorization required) | <input type="checkbox"/> Other _____ |

C. Time period or date of information to be released: From _____ To _____

D. I would like my images on (please check) CD disk Yes, if available, or No or Film Yes or No
(\$15 per CD) (\$15 per sheet)

E. I understand that the purpose(es) of the requested use and disclosure is (are):

- At the request of the patient Other _____

F. I understand that copies of the records indicated above will be: Please check one box.

Sent to: Name of Company/Individual _____
Attn _____
Address _____
City _____ State _____ Zip Code _____
Phone _____

Picked up by patient or designee: Name of Company/Individual _____
Attn: _____
Address _____
City _____ State _____ Zip Code _____
Phone _____

SECTION 3

- ◆ I understand that I may revoke this authorization in writing at any time, except to the extent that UT Southwestern Medical Center 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 **90 days** from the date of signature.
- ◆ 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 law, 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), a redisclosure 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 Guardian's Printed Name

Legal Guardian's Signature

Date

If guardian, specify relationship to the patient

**Note: Proof of guardianship may be required for guardians (family and legal representatives)*

Radiology or Office Use Only

Date received: _____ Date processed: _____
Processed by: _____ Date film mailed/picked up: _____
Date authorization revoked, if applicable: _____
Identification verified: No Yes _____ staff name
Fee collected: No Yes _____ amount
Comments: _____