

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 (UTSW) 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 Required Section Applies to All Requests

Note: This is a required section and must be completed in its entirety. Both pages of this authorization are required to be submitted. Records requested are provided in an electronic format (e.g. CD, MyChart, secure file portal) unless otherwise requested in paper format. *Electronic signatures are not accepted.*

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 for the requested information.**

- A. I understand that the information is to be released for the following purpose: **(Check all that apply)**
- | | | | |
|---|----------------------------------|--------------------------------------|--|
| <input type="radio"/> Attorney/Legal | <input type="radio"/> Healthcare | <input type="radio"/> Patient Record | <input type="radio"/> Self-Pay Financial Account Balance (MyChart) |
| <input type="radio"/> Billing or Claims | <input type="radio"/> Insurance | <input type="radio"/> Review Request | <input type="radio"/> Other _____ |
| <input type="radio"/> Disability | <input type="radio"/> Military | <input type="radio"/> School | |
- B. I understand the information requested will be released to:
- Name/Facility Name: _____
- Attention: _____
- Address: _____
- City: _____ State: _____ Zip Code: _____
- Phone: _____ Email: _____ Fax: _____
- C. All records will be delivered in an electronic format (CD, MyChart, or via secure file portal), unless otherwise specified:
- electronic paper **Note: Cost may vary by selection**
- D. Check requested delivery method: Secure File Portal Fax My Chart (patient only) Postal Mail
- Pick-Up Records (valid government-issued photo ID required) Other _____

Section 1 - General Medical Records – Check Only Boxes That Apply

- A. Information to be released:
- | | | | |
|---|---|--|---|
| <input type="radio"/> Billing Records | <input type="radio"/> Family Studies Records | <input type="radio"/> Laboratory Reports | <input type="radio"/> Pathology Slides |
| <input type="radio"/> Consultation Reports | <input type="radio"/> History & Physical | <input type="radio"/> Medication Sheets | <input type="radio"/> Pathology Reports |
| <input type="radio"/> Demographics Face Sheet | <input type="radio"/> Home Health | <input type="radio"/> MyChart Messages | <input type="radio"/> Pediatric Records |
| <input type="radio"/> Discharge Summary | <input type="radio"/> Hospital Progress Notes | <input type="radio"/> Office Visit Notes | <input type="radio"/> Procedure Records |
| <input type="radio"/> Emergency Department | <input type="radio"/> Immunization Record | <input type="radio"/> Operative Notes | <input type="radio"/> Radiation Treatment Records |
| <input type="radio"/> Explanted Materials,
Devices or Hardware | <input type="radio"/> Implant Records | <input type="radio"/> Pathology Blocks
(legal purpose only) | <input type="radio"/> Complete Medical Records |
| <input type="radio"/> Other _____ | | | |
- B. Time period or date of information to be released: From: _____ To: _____
 (Month / Year) (Month / Year)
- C. UTSW Treating Physician(s): _____ or All physicians
- D. UTSW 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.

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Section 2 - Imaging/Radiology Records - Check Only Boxes That Apply

- A. Information to be released:
- | | | | |
|-------------------------------------|--|---|---|
| <input type="radio"/> Bone Density | <input type="radio"/> EKG/ECHO | <input type="radio"/> MRI | <input type="radio"/> PET Scan |
| <input type="radio"/> CT/CAT Scan | <input type="radio"/> Interventional Radiology | <input type="radio"/> Nuclear Medicine Scan | <input type="radio"/> Sonogram/Ultrasound |
| <input type="radio"/> Dental Images | <input type="radio"/> Mammograms | <input type="radio"/> Ophthalmology Images | <input type="radio"/> X-ray |
| <input type="radio"/> Other _____ | | | |
- B. Reports Only Images Only Images and Reports
- C. Time period or date of information to be released: From: _____ To: _____
(Month / Year) (Month / Year)
- D. UTSW Treating Physician(s): _____ or All Physicians
- E. All records will be delivered in an electronic format (CD, Lifelimage or via secure file portal), unless otherwise specified:
 electronic paper **Note: Cost may vary by selection**
- F. Check appropriate delivery method: Secure File Portal Fax (Reports Only) Lifelimage Portal Pick-Up Postal Mail

Section 3 - Genetics, Psychiatry/Behavioral Health and Research Records – Check Only Boxes That Apply

- A. Genetics Records Specify: _____ Complete Medical Record
 Date(s) of information to be released: From: _____ To: _____ Physician Name (if known): _____
(Month / Year) (Month / Year)
- B. Psychiatry/Behavioral Health Records
 Certification of Health Care Provider Form Specify: _____ Complete Medical Record
 Date(s) of information to be released: From: _____ To: _____ Physician Name (if known): _____
(Month / Year) (Month / Year)
- C. Research Records Specify: _____ Complete Medical Record
 Date(s) of information to be released: From: _____ To: _____ Physician Name (if known): _____
(Month / Year) (Month / Year)

Section 4 – Student Health Record – Check Only Boxes That Apply

- A. Information to be released:
 Immunization Record Student Wellness and Counseling Record Complete Medical Record
- B. Date(s) of information to be released: From: _____ To: _____ Physician Name (if known): _____
(Month / Year) (Month / Year)

Patient Acknowledgement – This Section Applies to All Requests

- ◆ 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 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
(Electronic Signature Not Accepted)

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

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

If representative, specify relationship to the patient

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