

UT Southwestern Medical Center

Authorization to Receive External Protected Health Information

Pt. Name: _____

Address: _____

City State Zip

DOB: _____ SEX: _____

1. I hereby authorize: _____

Facility/Physician: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

To release the following information from the health record(s) of:

Patient's Name: _____ Date of Birth: _____

Covering the period(s) of treatment: From: _____ To: _____

2. Patient has an appointment on _____. Please send records prior to appointment date.

3. Information to be released:

Complete Medical Record (includes information regarding insurance, demographics, referral documents and records from other facilities)

Diagnostic Tests History & Physicals Laboratory Reports Progress Notes

Discharge Summary Imaging/Radiology Reports Operative Report Radiology Images

Other: _____

4. Information is to be released to: UT Southwestern Medical Center

Attn: _____

Address: _____

Mail Code: _____, Dallas, Texas 75390

Phone #: _____ Fax #: _____

5. I understand the purpose of these records is for continuity of care and physician review.

6. I understand this consent can be revoked in writing at any time except to the extent that disclosure of information has already occurred prior to receipt of the revocation by the releasing entity. If written revocation is not received, authorization will be considered valid for a period of time not to exceed **180 days**.

7. Specification of the date, event, or condition upon which this consent expires: (Please specify if applicable)

8. 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.

9. 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.

10. 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.

Authorization: Patient Signature
 Legal Representative (Proof of status as legal representative may be required)
 Verbal Telephone/MyChart Patient Confirmation Received (Receiving UTSW employee must sign with Title)

Patient or Legal Representative Printed Name

Signature

Date

Employee Printed Name and UTSW Title

Signature

Date

