

UT Southwestern Medical Center

Authorization to Disclose Protected Health Information

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 2 BBBBBBBBBBBBBBPHIDPHU BBBBBBBBBBBBBBBBBBBBBB
 (PDOGGUHHBBB

Instructions: BPSOHHDOODSSODOHBRBDHURUPDRGORHGWRPBBHHUOHGDOBHUBDRHUSURGHUBU
 UHTHRUBHHHUUOBBGRUHDPHSDPHBUROOPHBUBOORUBHIDHG BBBBPSOHRBIDRUP

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. Records requested are in electronic format (e.g. CD) unless requested in paper. Currently, electronic signatures are not accepted.

,HUUH DRUH 8 RHHUOHGDO HHU RGORH P SURHHG BDO IRUPDR B DOGBHUPHEG , OO
 HQUHTUHGBUSDH SUD DGRIGHDO SUSRH IDHJUDG DSURH DGSS IHHEDDSSOIRU UHTHHG
 IRUPDR

- ,GHUDGDEIRUPDRBBHOHDHGRUBUROOR SUSRH (Check all that apply)
 - BUHZHO BDODUH BDHERUG BDIHDDO RDOHDU
 - DOBUDDP UDH BHETH ZHU
 - DO ODU BRO

- ,GHUDGDEIRUPDRDHHTHHGDOBHHOHDHGB
 - 1DPH)DOIDPH _____
 - HR _____
 - GGUH _____
 - _____ DH _____ SBGH
 - 3RH _____ (PDO _____ ID _____

- OOHHRUGDOBBGHOHUHGDBOHURIRUPDEUD HOHUR IOH SRUDOOHBUHSHING
 - BOHUR SDSH *Note: Cost may vary by selection*
- M
 - Electronic File Portal My Chart (patient only) Postal Mail
 - Pick-Up Records (valid government-issued ID required) Other _____

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

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Note: GHUDGDEHURUGSBURGHGEBBPSOHHDDGGRRDGRPHDRDOBHBBDDGGHGURR
 RUHBIEDBHUDGDIDDHTDDBPSOHHSDSSURPDHOGDSRGDUH

Authorization to Disclose Protected Health Information

Patient Name: _____
 Other Names Used: _____
 Address: _____
 _____ City State Zip
 DOB: _____ Phone Number: _____
 Email Address: _____

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

- A. Information to be released:
- | | | | | |
|---|-------------------------------------|---|----------------------------------|-----------------------------------|
| <input type="radio"/> Bone Density | <input type="radio"/> Dental Images | <input type="radio"/> MRI | <input type="radio"/> PET | <input type="radio"/> X-ray |
| <input type="radio"/> Cardiac Catheterization | <input type="radio"/> EKG/ECHO | <input type="radio"/> Nuclear Medicine Scan | <input type="radio"/> Sonogram | <input type="radio"/> Other _____ |
| <input type="radio"/> CT / CAT Scan | <input type="radio"/> Mammograms | <input type="radio"/> Ophthalmology Images | <input type="radio"/> Ultrasound | |
- 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 Ordering/Treating Physician (if known): _____
- E. All records will be delivered in an electronic format (CD or via electronic file portal), unless otherwise specified:
 electronic paper **Note: Cost may vary by selection**
- F. Check appropriate delivery method: Electronic 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/Resident 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 may be required for legal representatives.

If representative, specify relationship to the patient

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