

**The University of Texas Southwestern Medical Center**  
Communications, Marketing, and Public Affairs Authorization Form

I hereby authorize the University of Texas Southwestern Medical Center (UT Southwestern), to disclose my protected health information and to interview me, and/or my physician(s) about my medical condition and/or to have photographs, print materials, and audio or audiovisual recordings made of myself. I understand that this information may be released by UT Southwestern to the news media or the general public through broadcast media in print or on the internet which may be subject to re-disclosure by them.

I also understand that my information will be released for the following purposes: fundraising, publicity, advertising or marketing for broadcast in print or other media including on the internet. I understand this authorization is voluntary and I may refuse to sign. UT Southwestern may not condition my health care services or payment, or enrollment or eligibility for benefits on the completion of this authorization form.

Unless otherwise revoked, I understand this authorization will expire 50 year(s) from the date of signature. I understand I may revoke this authorization at any time, except to the extent UT Southwestern has relied on this authorization, by sending a written statement of revocation that specifically refers to this authorization to:

Office of Communications, Marketing, and Public Affairs  
UT Southwestern Medical Center  
5323 Harry Hines Boulevard  
Dallas, TX 75390-9060

I understand that if my information would be disclosed for a marketing purpose as defined by the Health Insurance Portability and Accountability Act (HIPAA), then UT Southwestern could receive direct or indirect remuneration from a third party in connection with the use or disclosure of my information.

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. Your initials are required to release the following information:

\_\_\_\_\_ Mental Health Records (excluding psychotherapy notes) \_\_\_\_\_ Genetic Information (including Genetic Test Results)  
\_\_\_\_\_ Drug, Alcohol, or Substance Abuse Records \_\_\_\_\_ HIV/AIDS Test Results/Treatment

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 hereby release UT Southwestern, The University of Texas System, and their Regents, directors, officers, agents and employees from any and all liability, claims, suits, demands, or causes of action whatsoever which I, my heirs, representatives, executors, administrators, or any other person acting on my behalf or on behalf of my estate may have by reason of this authorization or the capture, use, or release of the reproductions.

**I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1).**

**By signing this authorization I represent to UT Southwestern, its agents and employees that I am of sound mind, and that I have read the authorization and fully understand the terms contained herein. I understand that UT Southwestern will provide me with a copy of this signed authorization form.**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**IF INDIVIDUAL HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:**

Print Name of Individual: \_\_\_\_\_

Print Name of Legal Representative: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**By signing this authorization, I certify that I have the legal authority to serve as the above named person's legal representative.**

Signature of Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

For Internal Use Only	
Verbal authorization received on: ____/____/____	By: _____
For: _____	
Authorization form mailed on: ____/____/____	