

Requesting Your Medical Records

To request and obtain your medical records, contact us in person, by email, mail, phone or fax, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

- **Email:** medical.records@utsouthwestern.edu
- **Mail:**
Health Information Management Department
Attn: Release of Information
5323 Harry Hines Blvd.
Mail Code 8525
Dallas, TX 75390-8525
- **Fax:**
214-645-9141
- **In Person:**
Health Information Management Release of Information
Suite: BLA.106
6333 Forest Park Road
Dallas, Texas 75390-8525
- **Phone:**
214-645-3030: Option 1, Option 1

UT Southwestern Medical Center is committed to protecting the privacy of your medical information. To safeguard your privacy, you must complete and sign the "Authorization to Disclose Protected Health Information" form before records can be disclosed. Please keep a copy of your completed authorization form for your records. You may also visit our website at <http://www.utsmedicine.org/patients-visitors/medical-records/> to find out more information concerning the release of your medical records and to download a printable authorization form (English and Spanish). Please note there is a turn-around time to process your request and fees may apply per the Texas state guidelines.

Instructions for Completing the Authorization to Disclose Protected Health Information Form

Note: If requesting to have your medical records sent directly to your physician or referring provider there is no charge. You may complete the "Authorization to Disclose Protected Health Information" form or have your physician's office fax or email us a request. If there is an upcoming appointment date, please indicate the date on the authorization form. The request must be submitted on their office letterhead with the name and signature of the person making the request. Please provide a contact number, so we can verify confirmation of the request. Please be advised patients seen at UT Southwestern Medical Center and are referred to other physicians within UT Southwestern Medical Center are not required to complete an authorization to release these medical records.

Please follow the instructions below carefully when completing the attached authorization form. Please write legibly, complete it in its entirety, and ensure to send back both pages. Failure to do so could result in a delay to process your request to release your medical record information. For assistance, please contact us at the above number and we will gladly walk you through the completion process.

1. **In the top right hand corner:** complete your name, if applicable other name(s) used, address, date of birth (DOB), phone number, and email address.
2. **In the Patient Notice Section A:** fill in the bubble that best describes the purpose of your request.
3. **In the Patient Notice Section B:** let us to know whom, where, and how your requested records should be sent by completing the name/facility name, attention to, address, city, state, zip code, phone number, email and fax number sections. Please note that only the person/facility name you place in this section can receive your records. A valid driver's license or government issued photo ID is required for proof of identity.
 - If you are requesting your own records, write your information in this section, if you want them sent to someone else (ex: family member, physician, insurance company, attorney or whomever you authorize us to release to then you would write their information in this section.
 - If you are requesting that we fax the record to your healthcare provider, please list the fax number and the phone number. It is important for us to have the phone number of the person you request us to fax your information to so we can confirm receipt of the information.
4. **In the Patient Notice Section C:** please indicate how you would like your medical records sent. Your records will be placed on a CD automatically unless you request differently. Costs may vary based on selection.
5. **Section 1 Type of Records:** where you would request and approve us to send specific type(s) of information. Please fill in the appropriate bubble(s) and indicate what period of time and/or physician, clinic, facility names.

6. **Section 2 Imaging/Radiology Record:** where you would request and approve us to send the radiology images and/or reports. Please fill in the appropriate bubble(s) and indicate type of image needed, date(s), and/or physician, clinic, facility names. If you are needing radiology images, please be sure to indicate the delivery method you prefer.
7. **Section 3 Genetics, Psychiatry and Research Records:** due to the sensitivity of these records, you must specifically indicate release of this information by filling in the appropriate bubbles and indicating what period of time and/or physician, clinic, facility names.
8. **Section 4 – Student Health Record:** due to the sensitivity of these records, you must also specifically indicate release of this information by filling in the appropriate bubbles and indicating what period of time and/or physician, clinic, facility names.
9. **Patient Acknowledgement:** it is important that you read all the information included in this section as it pertains to your rights and information that may be included in the release of your records. Once you have read this section, please indicate your acknowledgement by printing, signing your name, and dating the appropriate section. Please note that electronic signatures are not accepted.

Note: If the individual signing the authorization form is a Guardian, Executor of the Estate or Medical Power of Attorney for the patient, that person must submit a copy of the appropriate legal document, which proves authority to act on behalf of the patient. This must accompany the authorization form. To obtain medical records for incapacitated patients, you must provide a copy of the patient's Medical Power of Attorney. Please note that a Medical Power of Attorney is not valid upon death. When requesting records for a deceased patient, a death certificate is required that identifies the requesting party on the death certificate and proof that you are the executor of the deceased's estate.

Patient Request Fees:

In addition to the authorization form, please be advised that the below fees will be required prior to releasing the records. Please make checks or money orders payable to 'UT Southwestern Medical Center' and mail to the above address or you may contact our department to make a credit card payment. **Note:** There is no charge for your records if you are in the armed services, a veteran (ID required) or an employee of UT Southwestern Medical Center (employee badge required). There may be a cost of mailing, shipping, or otherwise delivering the provided copies.

Electronic Copy: Medical Records Burned on CD or Sent in Other Electronic Medium: \$6.50 flat fee

Paper Copy:

\$ 6.50 pages 1-10
\$ 25.00 pages 11-20
\$ 0.50 every additional page

Radiology Images on CD or Sent in Other Electronic Medium -Initial copy: no charge
-Multiple copies with the same dates of service: \$6.50

How do I obtain other types of records from UT Southwestern Medical Center?

Please contact the following departments:

<i>Itemized Billing Records</i>	<i>Student Health Records</i>
469-291-2000	214-645-8690

Other Records:

Parkland Memorial Hospital
Ph: 214-590-5470

Children's Medical Center
Ph: 214-456-2503