

# UT Southwestern Medical Center

Patient Label

## Healthshare Videoconferencing Authorization

### **I. AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO DESIGNATED PERSON(S).**

AT THE PATIENT'S REQUEST, THIS AUTHORIZATION GRANTS PERMISSION TO UT SOUTHWESTERN MEDICAL CENTER ("UT SOUTHWESTERN") TO COMMUNICATE VIA E-MAIL WITH THE FOLLOWING PERSONS, DESIGNATED BY THE PATIENT, TO PARTICIPATE IN UT SOUTHWESTERN'S HEALTHSHARE VIDEOCONFERENCING PROGRAM. THIS AUTHORIZATION IS APPLICABLE FOR ELECTRONIC INFORMATION ONLY AND IS NOT VALID FOR THE RELEASE OF THE PATIENT'S WRITTEN MEDICAL RECORD.

**I AUTHORIZE** UT Southwestern Medical Center to communicate with the person(s) listed below ("Designated Persons") for the following purposes: to notify them of my hospital admission; to make them aware of the HealthShare Videoconferencing Program; provide them technical information so that they may configure their personal devices to participate in videoconferencing; and to provide them with my patient room phone number and unique videoconferencing ID for this admission.

Please print the following information for each Designated Person (If there are more than 2 persons, please include on additional forms):

Name: _____	Relationship to the patient: _____
Address: _____	Email Address: _____
_____	Telephone: _____

Name: _____	Relationship to the patient: _____
Address: _____	Email Address: _____
_____	Telephone: _____

**I UNDERSTAND** that once this information is disclosed to the Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

**I UNDERSTAND** that this authorization will be effective for my lifetime, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time by sending a written statement of revocation to:

UT Southwestern Medical Center  
Release of Information Department  
5323 Harry Hines Blvd.  
Dallas, TX 75390-8525

If I revoke this authorization, it will not have any effect on any actions taken by UT Southwestern prior to processing the revocation.

### **II. PROVIDER USE OF HEALTHSHARE VIDEOCONFERENCING**

HEALTHSHARE VIDEOCONFERENCING ENHANCES PROVIDER COMMUNICATION WITH PATIENTS AND GIVES PROVIDERS AN ADDITIONAL WAY TO CHECK IN WITH PATIENTS AFTER THEIR DAILY IN-PERSON ASSESSMENT.

**I AUTHORIZE** UT Southwestern Providers to communicate with me via HealthShare Videoconferencing.

**I UNDERSTAND THAT UT SOUTHWESTERN'S HEALTHSHARE VIDEOCONFERENCING IS A COMMUNICATION TOOL AND WILL NOT BE USED FOR PROVIDING TELEMEDICINE SERVICES OR TELEHEALTH SERVICES.** This means: (i) the purpose of the videoconferencing will not be for your evaluation, diagnosis, consultation or treatment and (ii) all such medical services will be provided by UT Southwestern in person.

**I UNDERSTAND** that my physician may identify a change in my condition or treatment while communicating with me via videoconferencing, which will require an in-person medical evaluation.

**I UNDERSTAND** that this Authorization is voluntary, and my refusal to sign will not negatively affect my health care services at UT Southwestern Medical Center.

**Healthshare Videoconferencing  
Authorization**

BY SIGNING THIS AUTHORIZATION I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE STATEMENTS CONTAINED HEREIN. I ACKNOWLEDGE THAT I AM THE PATIENT OR I AM THE PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, AND/OR GUARANTOR AND CONSENT TO THE ABOVE ITEMS AND MAKE THE ACKNOWLEDGMENTS HEREBY MADE. I UNDERSTAND THAT UT SOUTHWESTERN WILL PROVIDE ME WITH A COPY OF THIS SIGNED AUTHORIZATION FORM.

\_\_\_\_\_  
Signature of Patient/Responsible Party (Relationship to Patient)

\_\_\_\_\_  
Time

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Interpreter/Provider Using Telephone Translation Services

\_\_\_\_\_  
Time

\_\_\_\_\_  
Date