UT Southwestern Medical Center

Authorization to Disclose Protected Health Information

Patient Name: _____

Other Names Used: _____

Address: _____

_____
City State Zip

DOB: _____ Phone Number: _____

Email Address: _____

Instructions: Complete all applicable sections to have information disclosed from UT Southwestern Medical Center (UTSW) to another provider or requestor. UT Southwestern will not condition treatment, payment, enrollment or eligibility for benefits based on the completion of this form.

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 required section must be completed in its entirety and both pages of this authorization form are required to be submitted. Records requested are provided in an electronic format (e.g. MyChart, CD, secure file portal) unless otherwise requested in paper format.

I hereby authorize UT Southwestern Medical Center to disclose my protected health information (PHI). A valid government-issued photo ID will be required for patient privacy and confidentiality purposes.
I understand a processing and shipping fee may apply for the requested information.

A. I understand that the information is to be released for the following purpose: **(Check all that apply)**

☐ Attorney/Legal ☐ Healthcare ☐ Patient Record ☐ Self-Pay Financial Account Balance (MyChart)
☐ Billing or Claims ☐ Insurance ☐ Review Request ☐ Other _____
☐ Disability ☐ Military ☐ School

B. I understand the information requested will be released to:

Name/Facility Name: _____

Attention: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____ Fax: _____

C. All records will be delivered in an electronic format (MyChart, CD, secure file portal), unless otherwise specified:
☐ electronic ☐ paper ***Note: Cost may vary by selection***

D. Check requested delivery method: ☐ Secure File Portal ☐ Fax ☐ My Chart (patient only) ☐ Postal Mail
Pick-Up Records (valid government-issued photo ID required) Other _____

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

A. Information to be released:

☐ Billing Records
☐ Consultation Reports
☐ Demographics Face Sheet
☐ Discharge Summary
☐ Emergency Department
☐ Explanted Materials, Devices or Hardware
☐ Family Studies Records
☐ History & Physical
☐ Home Health
☐ Hospital Progress Notes
☐ Immunization Record
☐ Implant Records
☐ Laboratory Reports
☐ Medication Sheets
☐ MyChart Messages
☐ Office Visit Notes
☐ Operative Notes
☐ Pathology Blocks (legal purpose only)
☐ Pathology Slides
☐ Pathology Reports
☐ Pediatric Records
☐ Procedure Records
☐ Radiation Treatment Records
☐ Complete Medical Records
☐ Other _____

B. Time period or date of information to be released: From: _____ (Month / Year) To: _____ (Month / Year)

C. ☐ UTSW Treating Physician(s): _____ ☐ or All physicians

D. ☐ UTSW Clinic/Hospital Name(s): _____

Note: I understand that the record provided may be incomplete and additional documentation will continue to be added throughout the course of my stay. I understand that I may request a complete copy at approximately 30 days post discharge.

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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:

☐ Bone Density ☐ CT/CAT Scan ☐ Dental Images ☐ EKG/ECHO ☐ Interventional Radiology ☐ Mammograms ☐ MRI ☐ Nuclear Medicine Scan ☐ Ophthalmology Images ☐ PET Scan ☐ Sonogram/Ultrasound ☐ X-ray

☐ Other _____

B. ☐ Reports Only ☐ Images Only ☐ Images and Reports

C. Time period or date of information to be released: From: _____ (Month / Year) To: _____ (Month / Year)

D. UTSW Treating Physician(s): _____ ☐ or All Physicians

E. All records will be delivered in an electronic format (CD, LifeImage or via secure file portal), unless otherwise specified:
☐ electronic ☐ paper ***Note: Cost may vary by selection***

F. Check appropriate delivery method: ☐ Secure File Portal ☐ Fax (Reports Only) ☐ LifeImage 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: _____ (Month / Year) To: _____ (Month / Year) Physician Name (if known): _____

B. Psychiatry/Behavioral Health Records

☐ Certification of Health Care Provider Form ☐ Specify: _____ ☐ Complete Medical Record

Date(s) of information to be released: From: _____ (Month / Year) To: _____ (Month / Year) Physician Name (if known): _____

C. Research Records ☐ Specify: _____ ☐ Complete Medical Record

Date(s) of information to be released: From: _____ (Month / Year) To: _____ (Month / Year) Physician Name (if known): _____

Section 4 – Student 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: _____ (Month / Year) To: _____ (Month / Year) Physician Name (if known): _____

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
*Legal Representative's Printed Name	Legal Representative's Signature	Date

_____
If representative, specify relationship to the patient

***Note:** Proof of legal authority will be required for legal representatives.

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

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