UT Southwestern Medical Center

Authorization to Receive External Protected Health Information

Pt. Name: _____

Address: _____

_____

City State Zip

MRN: _____

DOB: _____ SEX: _____

To release the following information from the health record(s) of:

Patient's Name: _____ Date of Birth: _____

Covering the period(s) of treatment: From: _____ To: _____

1. I hereby authorize: _____

   Facility/Physician: _____

   City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

2. Patient has an appointment on _____. Please send records prior to appointment date.

3. Information to be released:

- ☐ Consultations
- ☐ Diagnostic Tests
- ☐ Discharge Summary
- ☐ History & Physicals
- ☐ Laboratory Reports
- ☐ Operative Report
- ☐ Progress Notes
- ☐ Pathology Slides
- ☐ Pathology Reports
- ☐ Radiology Images
- ☐ Radiology Reports
- ☐ Other: _____
- ☐ Complete Medical Record (includes information regarding insurance, demographics, referral documents and records from other facilities.

4. Information is to be released to: UT Southwestern Medical Center

   Attn: _____

   Address: _____

   Mail Code: _____, Dallas, Texas 75390

   Phone #: _____ Fax #: _____

5. I understand the purpose of these records is for continuity of care and physician review.

6. I understand this consent can be revoked in writing at any time except to the extent that disclosure of information has already occurred prior to receipt of the revocation by the releasing entity. If written revocation is not received, authorization will be considered valid for a period of time not to exceed 180 days.

7. Specification of the date, event, or condition upon which this consent expires: (Please specify if applicable)

   _____

8. 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.

9. 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.

10. 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.

Authorization:

- ☐ Patient Signature
- ☐ Legal Representative (Proof of status as legal representative may be required)
- ☐ Verbal Telephone/MyChart Patient Confirmation Received (Receiving UTSW employee must sign with Title)

Signature of Patient	Printed Name of Patient	Time AM/PM	Date

or Legally Authorized Representative (Relationship to Patient _____)

Signature of UTSW Employee	Printed Name of UTSW Employee (and Title)	Time AM/PM	Date

FORM # 7680-008 (01/05) (Rev. 02/05/2025)

White – Health Information Management (HIM)