UT Southwestern Medical Center

Authorization to Disclose Protected Health Information

Patient Name: _____

Address: _____

_____

City State Zip

MRN: _____

DOB: _____ SEX: _____

Return form to:
Health Information Management – Release of Information
5323 Harry Hines Boulevard
Mail Code 8525
Dallas, Texas 75390-8525

Fax: 214-645-9141
Email: Medical.Records@UTSouthwestern.edu

Patient Notice – Please complete this form in its entirety.

A. Purpose: I understand that the information is to be released for the following purpose: **(Check all that apply)**
☐ Personal ☐ Continuity of Care ☐ Insurance/Billing ☐ Disability ☐ Legal ☐ Other: _____

B. Receiving Facility/Individual: I understand the information requested will be released to the following: **(Check one)**
☐ Self / Email: _____
☐ Requestor Name/Facility Name: _____ Attn: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Email: _____

C. Format Requested: ☐ Electronic ☐ Paper ☐ Media: CD/DVD (check one): ◯ Encrypted ◯ Unencrypted
☐ Other, specify: _____
Note: There is some level of risk that a 3rd party could see your information without your consent when receiving unencrypted electronic media. We are not responsible for unauthorized access to PHI contained in this format or any risks (e.g. virus) potentially introduced to your computer/device when receiving PHI in electronic format.

D. Delivery Method: (Delivered electronically if not otherwise specified. If unable to accommodate electronic delivery then an alternative method will be provided.)
Electronic: ☐ MyChart ☐ Secure File Portal (Encrypted) ☐ Imaging Platform (sends radiology images electronically; additional information may be required)
Other: ☐ Fax ☐ Pickup (Acceptable ID required) ☐ Mail ☐ Other, specify: _____

E. Information to be released: **(Check all that apply)** *Abbreviations used - History and Physical (H&P); Discharge Summary (DS); Procedure/Operative Report (OP); Physical Therapy (PT); Occupational Therapy (OT); Speech Therapy (ST); Electronic Health Information (EHI).*

☐ Abstract Hospital *(H&P, DS, OP, Consult, progress notes, diagnostic reports)*
☐ Abstract Clinic *(OP, progress notes, diagnostic reports)*
☐ Provider Reports *(H&P, DS, OP, Consult, progress notes)*
☐ Therapy Notes *(PT, OT, ST)*
☐ Discharge Summary *(DS)*
☐ Procedure/Operative Report *(OP/Cardiac Cath)*
☐ Pathology Report
☐ Labs
☐ Itemized Billing Statement
☐ Substance Abuse Therapy Records (*Please check if authorized to release as part of this request*)
☐ HIV/AIDS Records (*Please check if authorized to release as part of this request*)
☐ Genetics Records (*Please check if authorized to release as part of this request*)

☐ Radiology/Dental/Ophthalmology Images: **(Circle one)**
Procedure: _____
◯ Reports Only ◯ Images Only ◯ Reports and Images
☐ Psychiatry/Behavioral Health: _____
☐ Research: _____
☐ Student Health: _____
☐ Radiation Oncology: _____
☐ Home Health: _____
☐ Employee Assistance Program (EAP): _____
☐ Immunizations
☐ EHI Export File *(machine readable format only)*
☐ Specific Doctor/Location: _____
☐ Other: _____
_____
_____

F. Date range or date of service: ☐ Last 2 years or ☐ From: _____ (Month/Year) To: _____ (Month/Year)

G. Acknowledgement:

- 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.
- 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.
- UT Southwestern will not condition treatment, payment, enrollment or eligibility for benefits based on the completion of this form.
- This specific authorization form does not authorize the release of Substance Abuse Therapy records needed for civil, criminal, administrative, or legislative proceedings. 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.
- 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 to the extent that 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, please specify relationship to patient.

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

Form # 7680-001 (01/2005) (Rev. 08/13/2025) White - Health Information Management (HIM) Yellow - Patient