## Authorization to Disclose Protected Health Information

Pt. Name:____________________
Address:____________________
____________________
City State Zip
MRN: ____________________
DOB: ____________________
SSN: XXX-XX-__ __ __ __ SEX:______
DOS: ____________________

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

### Patient Notice
### This Section Applies to All Requests

I hereby authorize UT Southwestern Medical Center at Dallas (UT Southwestern) to disclose my protected health information. I understand a processing fee may apply for the requested information. Identification will be required for patient privacy and confidentiality.

A. I understand that the information is to be released for the following purpose:
Please fill in all bubbles that apply:
◯ Attorney ◯ Billing or Claims ◯ Patient Request ◯ Social Security Disability ◯ Treatment/Consultation
◯ Review Record: ____________________

B. I understand the information requested will be: Please mark one: ◯ Mailed to or ◯ Picked up by:
Name:____________________
Attn:____________________
Address:____________________
City:____________________ State:__________ Zip Code:__________
Phone:____________________

### Section 1 - Ambulatory - Outpatient Medical Record & Billing Request
### Information to be Routed and Processed by the Ambulatory Services Custodian of Medical Records

A. Information to be released:
**(Fill in all bubbles that apply)**
◯ Billing Records ◯ Progress Notes ◯ Labs
◯ Complete Medical Record (includes information regarding insurance, demographics, referral documents and records received from other facilities)
◯ Other:____________________

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

### Section 2 - Hospital - Inpatient Medical Record & Billing Request
### Information to be Routed and Processed by the Inpatient Custodian of Medical Records

A. Information to be released:
**(Fill in all bubbles that apply)**
◯ Blood Type ◯ Emergency Room Records ◯ Laboratory Reports ◯ Pathology Reports
◯ Consultation Reports ◯ Face Sheet ◯ Medication Sheets ◯ Progress Notes
◯ Discharge Summary ◯ History & Physical ◯ Newborn Records ◯ X-ray Reports
◯ EKG/ECHO ◯ Itemized Bill ◯ Operative Records ◯ Billing Records
◯ Other:____________________

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

### Section 3 - Oral Surgery Film, Reports, and Billing Request

A. Information to be released: ◯ Dental Images/Reports ◯ Billing Records

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

**Authorization to Disclose Protected Health Information**

Pt. Name:____________________
Address:____________________
____________________
City State Zip
MRN: ____________________
DOB: ____________________
SSN: XXX-XX-___ ___ ___ ___ SEX:______
DOS: ____________________

## Section 4 - Radiology Film, Images, and Billing Request

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

B. **Location of information:**

- ◯ Aston Radiology
- ◯ Rogers MRI
- ◯ Meadows MRI
- ◯ PET center
- ◯ Zale Lipshy Radiology
- ◯ St. Paul Radiology
- ◯ Simmons Breast Center
  - ◯ Temporary transfer
  - ◯ Permanent transfer

**Information requested:**

- ◯ CT / CAT Scan
- ◯ MRI
- ◯ Xray / Images
- ◯ PET scan
- ◯ Nuclear Medicine scan
- ◯ Ultrasound / Sonogram
- ◯ Bone density
- ◯ Mammograms
- ◯ Reports

*Note: Temporary transferred studies must be returned within 30 days from release date.

Would you prefer your images be recorded onto a CD? ◯ No ◯ Yes

## Section 5 - Home Health Records and Billing Request
## Information to be Routed and Processed by the Home Health Custodian of Medical Records

A. Information to be released: ◯ Home Health Records ◯ Billing Records

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

## Section 6 - Psychiatry or Genetics Records and Billing Request
## Information to be Routed and Processed by the Psychiatry or Genetics Custodian of Medical Records

A. Information to be released: ◯ Psychiatry Records ◯ Genetics Records ◯ Billing Records

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

## Patient Acknowledgement

- 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 HIPPAA, 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 may be required for legal representatives.

| Radiology Use Only | Release of Information Use Only |
|---|---|
| Date Received__________ Date Processed__________ | Date Received__________ Date Processed__________ |
| Processed By__________ Date Records Mailed/Picked Up__________ | Processed By__________ Date Records Mailed/Picked Up__________ |
| Date Authorization Revoked, if applicable __________ | Date Authorization Revoked, if applicable __________ |
| Fee for Records __________ | Fee for Records __________ |
| Fee Waived By __________ | Fee Waived By __________ |



Form # MSA/ADPHI-001 / 01.05 (Revised 08.05) White – Health Information Management Department Yellow – Patient

ROI/LEGAL