UT Southwestern
Medical Center

University Clinics

Authorization for Verbal Release of Protected Health Information to Designated Persons

Pt. Name:_____

Address:_____

_____
City State Zip

DOB: _____

SEX:_____

AT THE PATIENT'S REQUEST, THIS AUTHORIZATION GRANTS PERMISSION TO UT SOUTHWESTERN MEDICAL CENTER TO COMMUNICATE IN PERSON OR BY TELEPHONE WITH THE FOLLOWING PERSONS, DESIGNATED BY THE PATIENT, TO ASSIST WITH THE PATIENT'S HEALTH SERVICES. THIS AUTHORIZATION IS APPLICABLE FOR VERBAL INFORMATION ONLY AND IS NOT VALID FOR THE RELEASE OF THE WRITTEN MEDICAL RECORD.

I AUTHORIZE UT Southwestern Medical Center to communicate my health information to the person(s) listed below ("Designated Persons") for the following purposes: to orally confirm my appointments; to discuss results of my X-ray, laboratory or other test results; to pick up sample medications or written prescriptions for me; to discuss my health care, diagnosis, prognosis, and treatment plans; and to discuss billing and payment for medical services provided by UT Southwestern Medical Center.

Please print the following information for each Designated Person:

Name:_____ Relationship to the patient:_____

Address:_____ Telephone:_____

_____ Alternate Telephone:_____

_____

Name:_____ Relationship to the patient:_____

Address:_____ Telephone:_____

_____ Alternate Telephone:_____

_____

I UNDERSTAND that this authorization applies to all departments, healthcare providers and/or employees at UT Southwestern Medical Center.

I UNDERSTAND that this authorization is voluntary.

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 the authorization, it will not have any effect on any actions taken by UT Southwestern Medical Center prior to the processing of the revocation.

I UNDERSTAND that my refusal to sign this authorization will not negatively affect my health care services at UT Southwestern Medical Center.

Form # FMA/AVRPHIDP-001 / 11.03 (Rev. 02/17) Original – Health Information Management Department Copy – Patient
(Reviewed 09/13)

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Authorization for Verbal Release of Protected Health Information to Designated Persons

Pt. Name:_____

Address:_____

_____
City State Zip

DOB: _____

SEX:_____

BY SIGNING THIS AUTHORIZATION I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE STATEMENTS CONTAINED HEREIN. I UNDERSTAND THAT UT SOUTHWESTERN MEDICAL CENTER WILL PROVIDE ME WITH A COPY OF THIS SIGNED AUTHORIZATION FORM.

PATIENT:
Print name:_____

Signature:_____

Date:_____

IF PATIENT HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:
Print Name of Patient:_____
Print Name of Legal Representative:_____
Relationship to Patient:_____
By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative*.
Signature of Legal Representative:_____
Date:_____

**Proof of legal authority may be required. For more information on qualifications to serve as a patient's legal representative, see UT Southwestern Medical Center's Guidelines for Legal Representatives.*

Revocation of Authorization

This section is to be completed ONLY in the event the patient seeks to revoke the above authorization after signature.
By my signature below, I am revoking this authorization. I understand that this revocation will be effective when received by UT Southwestern Medical Center and will not be effective to the extent that UT Southwestern Medical Center has relied on my authorization prior to receiving notice of my revocation.

The designated person(s) to be revoked:_____
PATIENT:_____
Print name:_____
Signature:_____
Date:_____

IF PATIENT HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:
Print Name of Patient:_____
Print Name of Legal Representative:_____
Relationship to Patient:_____
By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative*:
Signature of Legal Representative: _____
Date:_____

**Proof of legal authority may be required. For more information on qualifications to serve as a patient's legal representative, see UT Southwestern Medical Center's Guidelines for Legal Representatives.*

This Section for Internal Use Only

Date revocation received:_____ Date revocation processed:_____

Name of employee processing request:_____

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