UT Southwestern Medical Center

Pt. Name: _____

Address: _____

_____

City State Zip

MRN: _____

DOB: _____ SEX: _____

Authorization for Verbal Release of Protected Health Information to Designated Persons

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:_____

City State Zip

Name:_____ Relationship to the patient:_____

Address:_____ Telephone:_____

_____ Alternate Telephone:_____

City State Zip

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 in situations in which I am incapacitated or an emergency, UT Southwestern may verbally disclose my PHI without my authorization to Persons involved in my care or payment.

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.

UT Southwestern Medical Center

Authorization for Verbal Release of Protected Health Information to Designated Persons

Pt. Name: _____

Address: _____

_____

City State Zip

MRN: _____

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.

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

IF PATIENT HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:

Printed Name of Patient:_____

Printed Name of Legal Representative: _____

Relationship to Patient:_____

By signing this authorization, I certify that I have legal authority to serve as the above named patient's legal representative.*

Signature of Legal Representative	Time AM/PM	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.*