UT Southwestern Medical Center

Authorization to Disclose Protected Health Information

Pt. Name: _____

Address: _____

_____
City State Zip

DOB: _____

SSN: XXX-XX-____ ____ ____ ____ SEX: _____

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: Life Insurance

B. I understand the information requested will be: Please mark one: ◯X Mailed to or ◯ Picked up by:

Name: Hoosier Services Inc.
Attn: Cathy He
Address: 18032 Lemon Dr., C-618
City: Yorba Linda State: CA Zip Code: 92886
Phone: 800.882.4156 / 800-882-4957 Fax

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 ◯X Progress Notes ◯X Labs
◯X 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
◯ Outpatient Building ◯ 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)

White – Health Information Management Department Yellow – Patient

Form # MSA/ADPHI-001 / 01.05 (Rev. 10.01.14) (Reviewed 09/13)

UT Southwestern Medical Center

Authorization to Disclose Protected Health Information

Pt. Name:_____

Address:_____

_____
City State Zip

DOB: _____

SSN: XXX-XX-____ ____ ____ ____ SEX:_____

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
- ◯ Outpatient Building Imaging Center
- ◯ 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 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	Time	Date
*Legal Representative's Printed Name	Legal Representative's Signature	Time	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 (Rev. 10.01.14) White – Health Information Management Department Yellow – Patient
(Reviewed 09/13)