THE UNIVERSITY OF TEXAS
HEALTH CENTER AT TYLER
11937 US Highway 271 Tyler, Texas 75708-3154

Patient Name: _____

Patient MRN: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, OTHER RELATIVES, OR FRIENDS INVOLVED IN MY CARE

This authorization may not be used to release or obtain documented information

_____ / _____ /Expires one year from date of signature

Patient Name DOB

AT MY REQUEST, I AUTHORIZE THE UNIVERSITY OF TEXAS HEALTH CENTER AT TYLER TO DISCLOSE INFORMATION INCLUDING, BUT NOT LIMITED TO MY DIAGNOSIS, RESULTS OF EXAMS, LAB RESULTS, DIAGNOSTIC TESTS, OPERATIVE, PATHOLOGY AND RADIOLOGY REPORTS, AND CONSULTATION REPORTS TO THE INDIVIDUALS LISTED BELOW WHO WILL BE DIRECTLY INVOLVED IN MY CARE AND TREATMENT.

This authorization does not permit the disclosure of information relating to HIV test results or treatment for AIDS, my history or treatment of drug or alcohol abuse, or mental health care. I understand that I have the right to further limit the protected health information that is to be released.

NAME	RELATIONSHIP	PHONE NUMBER (Optional)
1.		
2.		
3.		

(Please cross out any unused lines)

- I understand that the information disclosed by this authorization may be subject to re-disclosure by the person that received the information and is no longer protected by state and federal privacy laws.
- I understand that treatment at UTHCT will not be denied if I do not sign this authorization
- I understand that I can revoke this authorization at any time but I cannot revoke this authorization to the extent that UTHCT has taken action in reliance on the authorization.
- Unless revoked, this authorization will expire one year from the date of signature.

_____ _____

Patient/Legally Authorized Representative w/ Description of Authority **Date**

_____

Witness **Date**

REVOCATION OF AUTHORIZATION

I,_____, hereby revoke or cancel this authorization effective _____.
Date

_____ _____

Patient/Legally Authorized Representative w/ Description of Authority **Date**

_____ _____ _____ _____

Witness **Date** **Witness** **Date**

Approved by MIMC, Revised 08/04