PERMISSION TO SHARE HEALTH INFORMATION

By signing this form, I give UT Health Austin my permission to communicate, in person or by telephone, with the persons listed below about the patient’s care. This form does not allow UT Health Austin to release written or digital medical records.

I would like the following health information to be shared with the person(s) above:

☐ All health information  ☐ Past/Present Medications
☐ Diagnosis, prognosis and treatment plans  ☐ Test Results, Reports & Images (lab, radiology, EKG)
☐ Billing and payment information  ☐ Other
☐ Patient Information

I understand this permission covers all aspects of UT Health Austin.

I understand this is my choice, and my refusal to sign this form will not affect my care or treatment at UT Health Austin.

I understand that once my health information is shared with the people above, that they may share it and state or federal privacy laws may no longer protect my information.

This form will expire, unless revoked sooner by me, in over year following my death.

I understand I may revoke my permission at any time. If I revoke my permission, it will not have any effect on any actions taken by UT Health Austin prior to revocation.

Upon request, I will receive a copy of this signed form.

______________________________________  _________________________________________
Date       Printed name of Patient or Patient’s Representative

______________________________________  _________________________________________
Signature of Patient/Representative   Representative’s Authority (Relationship to Patient)