The University of Texas at Austin
University Health Services
Division of Student Affairs

PLEASE PRINT

PATIENT NAME: _____

EID: _____

DOB: _____ PHONE: _____

PROVIDER: _____ DATE: _____

Consent for Verbal Disclosure of Health Information

Patient:

I _____ authorize _____ or designee to disclose and/or receive the following protected health information to/from:

PRINT NAME OF PATIENT — NAME OF UHS STAFF MEMBER

_____ _____

PERSON TO WHOM INFORMATION IS TO BE DISCLOSED/RECIEVED — PHONE NUMBER

_____

RELATIONSHIP TO PATIENT

Brief Summary of Information to be Released:

☐ Today's visit, but do not disclose information about: _____

☐ All visits regarding: _____, but do not disclose information about: _____

☐ All health information, but do not disclose information about: _____

Term of Consent of Disclosure:

☐ Ongoing until revoked by patient

☐ Effective date signed through: _____

_____ _____

PATIENT SIGNATURE — DATE

Reviewed/Witnessed by: _____ _____

UHS STAFF SIGNATURE / DEPARTMENT — DATE

This authorization is revoked:

_____ _____

PATIENT SIGNATURE — DATE

If mailing or faxing form, please include a copy of a photo ID with signature.

Mail to:
The University of Texas at Austin
University Health Services
Health Information Management Department
P.O. Box 7339
Austin, Texas 78713-7339

Fax to:
512-475-8282