

THE UNIVERSITY OF TEXAS AT AUSTIN
UNIVERSITY HEALTH SERVICES

Consent for Verbal Disclosure of Health Information

(PLEASE PRINT)	
PATIENT NAME: _____	
EID: _____	
D.O.B.: _____	PHONE: _____
PROVIDER: _____	DATE: _____

Patient:

I _____ authorize _____ or designee
PRINT NAME PATIENT NAME OF UHS STAFF MEMBER

to disclose the following protected health information to:

PERSON TO WHOM INFORMATION IS TO BE DISCLOSED PHONE NUMBER

RELATIONSHIP TO PATIENT

Brief Summary of Information to be Released:

Visits Regarding: _____

Exclusion, if any: _____

Expiration Date of Authorizations, if any: _____

I may revoke this authorization in writing at any time, except to the extent that UHS has already relied on the authorization.

PATIENT'S SIGNATURE DATE

Patient Identification

Verified by: _____
UHS STAFF SIGNATURE / DEPARTMENT DATE

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

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

Fax to: 512-475-8282

Go to healthyhorns.utexas.edu/consent to download this form.