The University of Texas at Austin
UT Health Austin

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.

Designated Person	**Designated Person**
Name: _____	Name: _____
Phone: _____	Phone: _____
Relationship to Patient: _____	Relationship to Patient: _____

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

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

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)*