Please Complete Entire Form NEED HELP? EMAIL Privacyofficer@utsystem.edu
Form HIPAA Authorization

THE UNIVERSITY OF TEXAS SYSTEM ADMINISTRATION
HIPAA PRIVACY MANUAL

General Authorization for the Use and Disclosure of Protected Health Information

By signing this form, I hereby authorize The University of Texas System to obtain, use and disclose certain protected health information from the records of:

Name: ________________________ Daytime Phone # ____________________

Address: ____

DOB:____________ Benefits ID #* ____________ Email address:__________________

The following information may be used and disclosed (specifically identify the records, if entire medical record is requested state that): ____
____ _
____
____
____

The persons or class of persons who are authorized to receive this information are (either name specific individuals or the type of persons. An example of a class would be "anyone acting on behalf of Dr. X):
____
____
____
____

The purpose for which the records will be used or disclosed is as follows (check one):
☐ At the request of the individual
☐ Other (specifically identify the purpose): ________________________________

I understand that I may revoke this authorization in writing at any time, except that such revocation will not affect actions already taken in reliance on this authorization and, if applicable, may not be effective as to an insurer's right to contest a claim. I understand that, in order to revoke this authorization, I must send a written notice stating my intent to revoke this authorization to:

Privacy Officer, Systemwide Compliance,
The University of Texas System
201 West 7th Street, Suite 300
Austin, Texas 78701

Unless revoked earlier, this authorization will expire (choose only 1):
☐ On the following date: ____
☐ Upon the following event: ____

If no expiration date or event is given, it is assumed that the authorization will expire one year after it is signed.

I understand that System is not conditioning treatment, payment, enrollment in a group health plan, or eligibility for group health plan benefits upon my agreement to sign this Authorization.

* You can look up your UT System Benefits ID number at:
https://utdirect.utexas.edu/nlogon/sgwww/SGPNIBID.WBX

I understand that the information to be used and disclosed pursuant to this authorization form may include sensitive information such as information relating to (1) human immunodeficiency virus ("HIV") infection or acquired immunodeficiency syndrome ("AIDS"), (2) treatment for or history of drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care.

I understand that to the extent any recipient of this information, as identified in Paragraph 3 above, is not a "covered entity" under federal privacy law, the information may no longer be protected by federal privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

Signature: ________________________________ Date: ____________________________

If the authorization is signed by a Legal Representative of the Individual:

Printed name of Legal Representative: ____

Representative's authority to act for the Individual: ____________________________________

If signed by a Personal Representative of the individual, we *must* verify that you are this Individual's representative under state law for purposes of filing this Authorization before we can act on it. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc). As this person's representative, can you be contacted at the address, e-mail or phone number listed above? If not, please provide your mailing address, e-mail address and phone number: