THE UNIVERSITY OF TEXAS AT DALLAS

CALLIER CENTER FOR COMMUNICATION DISORDERS

Authorization Form

For the Use and Disclosure of Protected Health Information by the University of Texas at Dallas Callier Center for Communication Disorders

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Patient Name (print): ____________________
Social Security Number:____________________
Date of Birth: ____________________
Physical Address: ____________________
Mailing Address: ____________________
Telephone: ____________________ **Cell:** ____________________

By signing this Authorization Form, I understand that I am giving my authorization to the UTD/Callier Center's designated medical record custodians or database custodians to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the following person(s) or organization(s):

Name of person(s) or organization(s): ____________________
Street address: ____________________
City, State, and zip code: ____________________
Telephone number: ____________________
Facsimile number: ____________________
For additional organizations, see attachment.
Number of additional organizations (must be answered to be valid): ____________________

If you are requesting a copy of a consultation/psychotherapy summary maintained by a mental health provider, a separate authorization form must be completed.

I specifically authorize the use and disclosure of the following PHI:
(Please provide a detailed description of the particular data and period of time you are requesting.)

__ Audiology Reports ____________________

__ Speech-Language Reports ____________________

__ Speech-Language Therapy Notes ____________________

__ Other ____________________

If this authorization is for any purpose other than release of medical records for personal reasons, please state the purpose of the authorization to release PHI below:

The information to be used or disclosed pursuant to this authorization form may include information relating to (1) Acquired Immunodeficiency Syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care. I may revoke this authorization at any time by notifying UTD/Callier Center in writing to attention of

Medical Records Supervisor, 1966 Inwood Rd., Dallas, TX 75235 of my of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by UTD/Callier Center before UTD/Callier Center received my written notice of revocation.

Unless earlier revoked, this authorization will expire on the 365th day of the signing or as otherwise specified below:

If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy law.

I may inspect and receive a copy ***(Texas law establishes nominal fees for copy charges of medical records)*** of the information to be used and disclosed pursuant to this Authorization form.

This Authorization is voluntary and I may refuse to sign this Authorization form.

If I am providing authorization for marketing purposes, I understand that UTD/Callier Center may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient's PHI. **INITIAL BOXES BELOW TO CONSENT.**

__ I received a Notice of Privacy Practices

__ I authorize UTD/Callier Center to contact me by telephone regarding the scheduling or scheduled appointments.

__ I authorize UTD/Callier Center to leave a voice mail message regarding the scheduling or scheduled appointments on a telephone number specified by me.

__ I authorize UTD/Callier Center to mail an appointment reminder postcard to an address specified by me.

I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from UTD/Callier Center.

______________________________ ______________________

Signature of patient or surrogate decision maker **Date**

____

Printed name of patient

____

Printed name of surrogate decision maker *(if applicable)*

____

Relationship to patient giving representation authority to act for patient *(if applicable)*

(REV04.16.03)

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