UTHealth
East Texas Physicians

Acknowledgment of Privacy Practices

Dear Patient,

You have been given a copy of our Privacy Practice policy. Please complete the statement listed below and sign this Acknowledgment. If you have any questions regarding the information set forth in UT Health's Notice of Privacy Practices, please do not hesitate to contact the Privacy Office at (903) 596-3388.

I, _____, have received a copy of the UT Health Physicians' Notice of Privacy Practices. I understand that unless I object in writing that my health information can be disclosed for any of the outlined reasons given in the Notice of Privacy Practices.

_____ _____ _____

Signature DOB Date

If unable to give to patient, please explain:

_____

Authorization for Verbal Release of Information

Authorization for Use or Disclosure of Information for UT Health Physicians

I, _____, hereby authorize UT Health Physicians to disclose my protected health information to:

_____

_____

_____

**This protected health information is being used or disclosed for the following purposes: Information directly related to treatment, payment and/or healthcare operations. The information may include, but not be limited to, medical information, demographics, insurance, date of service, type of service, charges (reasons for denial or patient responsibility), etc.
***This authorization shall be in force and effective until December 31, 2020, at which time this authorization to use or disclose your protected health information expires. Upon expiration you will be required to sign a new authorization sheet.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient Personal Representative

Description of Personal Representative's Authority: _____