



Authorization for the Release of Protected Health Information for Education Purposes

Patient's Name (Print) _____ **Date of Birth** _____

Parent or Legal Representative's Name _____

Patient's Address _____ **Phone Number** _____

1. I hereby authorize The University of Texas Health Science Center at San Antonio ("UT Health San Antonio") to use and disclose my protected health information (PHI), including, but not limited to, clinical data and radiology images, for educational purposes. My PHI may be used and disclosed for education offered or directed by my UT Health San Antonio physician or health care provider in any format or forum which may include, but not be limited to, publication in written or online media, books or journals, classroom instruction and/or medical training at UT Health San Antonio or other educational institutions, and/or at local national and global conferences or other professional or educational events.
2. I further agree that UT Health San Antonio shall have all right, title, and interest in all text, images, sound records, videos or other items created as a result of this authorization (including finished pictures, negatives, reproductions, and copies of the original print).
3. I understand that I will not receive remuneration for releasing my PHI for the purpose(s) listed above.
4. I hereby release UT Health San Antonio and the University of Texas System and its Regents, officers, agents, and employees from any and all liability that may arise from the release of my PHI as authorized by this form. Furthermore, I waive any right to inspect or approve the finished product, including a written copy or edited video/presentation wherein my PHI is used or disclosed.
5. I understand that I may revoke this authorization at any time by sending written notice to UT Health San Antonio's Institutional Compliance and Privacy Office at compliance@uthscsa.edu. I understand that such revocation will have no effect on information already used, disclosed, and released by UT Health San Antonio prior to UT Health San Antonio's receipt of my written notice of revocation.
6. I may refuse to sign this authorization, and I cannot be denied or refused treatment if I refuse to sign and my refusal to sign this authorization will not affect my treatment, payment, enrollment or eligibility for benefits or the quality of care I receive.
7. I understand that any information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law.
8. This authorization shall not have an expiration date and shall remain in effect unless and until I provide my written revocation to UT Health San Antonio's Institutional Compliance and Privacy Office.

My signature below indicates that I have read and understand this authorization and am giving permission for the use and disclosure of my PHI as described above.

Patient Signature

Date

Signature of Parent/Legal Representative

Date

Parent or Legal Representative Power of Attorney Next of Kin of Deceased Executor of Estate