

Office of Development Patient Authorization Form

Purpose: The purpose of this form is to facilitate a dialog among physicians, professional staff of the Office of Development, and patients who may have interest in learning more about philanthropic activities and how they can advance the mission of The UT Health Science Center (Health Science Center) for continued excellence in care, research and education by assisting the University in providing scholarly teaching, innovative scientific investigation and discovery, and state-of-the-art patient care in a learning environment to better the health of society.

By giving permission to the Office of Development to use limited protected health information from your record, we are able to continue to include you in discussions about the institutions' priority education, clinical and research programs, including philanthropy, and to continue to visit you while you are on our campus.

Please be assured that protected health information will always be maintained with the strictest confidentiality.

1. I hereby authorize the Health Science Center, Office of Development, to appropriately use the following limited protected health information (PHI) from my record:

_____ My PHI, including but not limited to, my physician name(s) and areas of clinical service. (Your physician may advise this office of your research interests and facilitate the appropriateness of our relationship.) *[Please initial.]*

_____ My future appointments schedule. (This will allow the professional staff of the Development Office to continue to visit you while you are on our campus.) *[Please initial.]*

1. I understand that I may request to discontinue my participation in philanthropic activities at the Health Science Center including election of the option to discontinue receiving fundraising literature in the future. I may notify the Office of Development, 7703 Floyd Curl Drive, Mail Code 7835, San Antonio, TX 78229-3900 of my intent to no longer participate in philanthropic activities or receive fundraising information from the Health Science Center.
2. I understand I may revoke this authorization in writing at any time except to the extent that the Health Science Center has already relied on this authorization. I understand that I may revoke this authorization by sending a written notice stating my intent to revoke this authorization to the Office of Development, 7703 Floyd Curl Drive, Mail Code 7835, San Antonio, TX 78229-3900.
3. Unless revoked earlier, I understand this authorization will expire on the 365th day of the signing unless a lesser date is specified: _____. *[Please initial]*
4. I understand my treatment will not be based on the completion of this authorization form.
5. I understand that donations are voluntary and the presence or absence of my donation does not affect the type or quality of treatment given to me. I also understand that signing this authorization is voluntary, and declining to do so will not affect my health-care treatment at Health Science Center.

 Signature of Patient (or Patient Representative)

 Date

 Telephone Number

 Printed Name of Patient or Patient Representative

 Authority of Representative to Act for Minor Patient

 Relationship to Patient