



Office of Institutional Advancement

**Purpose:** The purpose of this form is to facilitate a dialog among physicians, professional staff of the Office of Institutional Advancement, and patients who may have interest in learning more about philanthropic activities and how they can advance the mission of UT Health San Antonio 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 Institutional Advancement 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 UT Health San Antonio, Office of Institutional Advancement, 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 Office of Institutional Advancement 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 UT Health San Antonio including election of the option to discontinue receiving fundraising literature in the future. I may notify the Office of Institutional Advancement, 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 UT Health San Antonio.
2. I understand I may revoke this authorization in writing at any time except to the extent that UT Health San Antonio 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 Institutional Advancement, 7703 Floyd Curl Drive, Mail Code 7835, San Antonio, TX 78229-3900.
3. Unless revoked earlier, I understand this authorization will expire on the 365<sup>th</sup> 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 UT Health San Antonio.

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Signature of Patient (or Patient Representative)

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Date

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Telephone Number

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Printed Name of Patient or Patient Representative

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Authority of Representative to Act for Minor Patient

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Relationship to Patient