THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO

PATIENT AUTHORIZATION RELEASE FORM

Date: _____ Phone: _____

Printed name of patient: _____

Printed name of Parent/Legal Guardian if any): _____

(a) I authorize the health care professionals who treated me through The University of Texas Health Science Center at San Antonio to release and discuss patient information about their treatment of my medical condition, or related topics, (or patient information regarding their treatment, the medical condition or related topics, of my child or an individual to whom I provide guardianship). No special favors, payment or other compensation have been promised to me for agreeing to this authorization. Finally, I understand that the patient information that is released will be current as of the time this Authorization is signed and that, if additional information is needed at a later date, I may be asked to sign another Authorization Release Form.

(b) I release the Health Science Center San Antonio, and its spokespeople, from any and all state or federal laws relating to patient privacy.

(c) I specifically authorize officials from the Health Science Center to share this health information (or that of child, or an individual to whom I provide guardianship) with members of the news media.

(d) I voluntarily give my permission for Health Science Center staff to represent me (or my child or an individual to whom I provide guardianship) on video/audio tape, photographic film or any other medium including social media.

(e) I authorize use of my (or my child's or an individual's to whom I provide guardianship) name, likeness, voice and biographical material in Health Science Center publications and website – to include electronic and printed magazines, brochures, newsletters and the Internet and its social media (e.g., Facebook, Twitter, etc.) – for publicity for the University and its programs.

(f) I give the Health Science Center the right to exhibit or distribute such representations in whole or in part, without limitations, for any educational purpose that the Health Science Center, and those acting under its authority, deems appropriate.

(g) I understand that I may withdraw or revoke my authorization at any time and such revocation must be given to the Health Science Center in writing. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, I understand that any disclosure or publication made prior to a revocation may remain in public domain. I further understand that such withdrawal of authorization will not affect my treatment.

Signature of Patient, Parent or Legal Guardian: _____