

**Family Wellness Center  
School of Nursing  
The University of Texas at Austin**

**Consent for Verbal Disclosure of Health Information**

**Patient:**

I \_\_\_\_\_ authorize \_\_\_\_\_ or  
PRINT NAME OF PATIENT NAME OF FWC STAFF MEMBER

designee to disclose the following protected health information to:

\_\_\_\_\_  
PERSON TO WHOM INFORMATION IS TO BE DISCLOSED PHONE NUMBER

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

**Brief Summary of Information to be Released:**

- Visits Regarding: \_\_\_\_\_  
\_\_\_\_\_
- Exclusion, if any: \_\_\_\_\_  
\_\_\_\_\_
- Expiration Date of Authorizations, if any: \_\_\_\_\_

I may revoke this authorization in writing at any time, except to the extent that the FWC has already relied on the authorization.

\_\_\_\_\_  
PATIENT'S SIGNATURE DATE

**Patient Identification Verified by:**

\_\_\_\_\_  
FWC STAFF SIGNATURE DATE

If mailing or faxing form, please include a copy of a photo ID.

**Mail to:** Family Wellness Center  
The University of Texas at Austin  
School of Nursing  
2901 N. IH 35  
Austin, TX 78722

**Fax to:** 512-471-1455

