OBSERVER AUTHORIZATION

OBSERVER NAME: _____

I authorize my physician and (organization name) _____ to permit, in addition to the physicians and hospital workforce, the above named person to observe while I am undergoing planned treatment, for the following purpose:

- ❑ Procedure Observation
- ❑ Site Visit
- ❑ Job Shadowing
- ❑ Training
- ❑ Other

This observation may include release or disclosure of my treatment or other health information. Observers are required to agree to confidential treatment of any patient information to which they have access.

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I also understand that my treatment at this Hospital will not be based on my decision to sign this authorization.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name

_____ _____
For Departmental Use: MRN# Relationship to Patient

Texas Health Resources

Observer Authorization
(12/12)

Patient Identification

- ❑ Texas Health Arlington Memorial Hospital
- ❑ Texas Health Harris Methodist Hospital Alliance
- ❑ Texas Health Harris Methodist Hospital Azle
- ❑ Texas Health Harris Methodist Hospital Cleburne
- ❑ Texas Health Harris Methodist Hospital Fort Worth
- ❑ Texas Health Harris Methodist Hospital Hurst-Euless-Bedford
- ❑ Texas Health Harris Methodist Hospital Southwest Fort Worth
- ❑ Texas Health Presbyterian Hospital Allen
- ❑ Texas Health Presbyterian Hospital Dallas
- ❑ Texas Health Presbyterian Hospital Denton
- ❑ Texas Health Presbyterian Hospital Kaufman
- ❑ Texas Health Presbyterian Hospital Plano
- ❑ Texas Health Physician Group
- ❑ Other_____