Authorization to Disclose Protected Health Information (or other confidential information)

This authorization complies with the requirements of §164.508 of the HIPAA Privacy Standards (45 CFR, Parts 160 and 164)

Name: _____
(Name of Individual)

Address: _____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

Date of Birth: _____
(Of Individual)

I authorize the following person or entity:

_____
(Specify the Individual, Physician, Hospital, Clinic, Attorney, Counselor, School, Governmental entity, etc.)

_____ TX _____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

To disclose the following specific protected health or other confidential information:

Yes ( ) No ( ) Medical or Health Information. Indicate specific information: _____

If yes, please provide Mother's first and last name: _____

Yes ( ) No ( ) HIV-Related Information. Indicate specific information:

Yes ( ) No ( ) Psychological Reports. Indicate specific information:

Yes ( ) No ( ) Social History. Indicate specific information:

Yes ( ) No ( ) Other. Indicate specific information:

To the following individual or entity:

_____
(Name or Position of Individual / Entity authorized to receive information)

_____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

The information disclosed may be used by the individual or entity receiving the information for the following purpose(s):

I understand that: 1) I may revoke this authorization in writing by contacting the DSHS office or program that obtained the authorization; 2) this authorization will not affect treatment, payment, enrollment, or eligibility for benefits; and 3) information disclosed as a result of this authorization could be subject to re-disclosure as authorized by law.

EXPIRATION DATE: This authorization will expire on [date or event] _____
(If no date or event is stated, expiration is one year from the date it is signed.)

This form (___) was read by me (___) was read to me and I understand its purpose and content. All blanks were completed or struck through before I signed the form.

_____ _____
Signature of Individual or Parent of Individual of minor Date signed

_____
(Print / Type Name of Personal Representative state their authority to act to act on behalf of individual. Attach documents to support authority)

_____
(Signature of Personal Representative

_____
(Address) (Telephone)

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us/ for more information.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____)_____ **ALT. PHONE** (____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

- _____Mental Health Records (excluding psychotherapy notes)
- _____Drug, Alcohol, or Substance Abuse Records
- _____Genetic Information (including Genetic Test Results)
- _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**