AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____

Last **First** **Middle**

Home Address: _____

_____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED: **The information that may be disclosed under this Authorization includes:** _____

_____.

MY HIGHLY CONFIDENTIAL INFORMATION**:**

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

RECIPIENT: **Name of person or class of persons to whom [ORGANIZATION] may disclose my health information:** _____.

Address of the recipient or where my health information should be delivered:_____

_____.

TERM: **This Authorization will remain in effect:**

☐ **From the date of this Authorization until the _____ day of _____, 20___.**

☐ **Until [ORGANIZATION] fulfills this request.**

☐ **Until the following event occurs:** _____.

☐ **Other:** _____.

PURPOSE: **I authorize [ORGANIZATION] to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):** [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]_____.

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I understand that once [ORGANIZATION] discloses my health information to the recipient, [ORGANIZATION] cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Texas law governing the use and disclosure of my health information.

I understand that [ORGANIZATION] may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at [ORGANIZATION]; except, however, if my treatment at [ORGANIZATION] is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case [ORGANIZATION] may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to **[ORGANIZATION]'**s Privacy Office at the address listed below. The revocation will be effective immediately upon **[ORGANIZATION]**'s receipt of my written notice, except that the revocation will not have any effect on any action taken by **[ORGANIZATION]** in reliance on this Authorization before it received my written notice of revocation.

I may contact [ORGANIZATION]'s Privacy Office by mail at _____, _____, OR _____, by telephone at ( )___-____ or by e-mail at _____@_____.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize [ORGANIZATION] to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Authorized Personal Representative | Relationship to Patient | Date