CENTRAL HEALTH
TRAVIS COUNTY HOSPITAL DISTRICT

AUTHORIZATION FOR DISCLOSURE, USE OR RELEASE OF PROTECTED HEALTH INFORMATION

If you have questions about this form, please connect with any Central Health staff member for assistance.

For behavioral health related protected health information please use Authorization for Disclosure, Use or Release of Protected Behavioral Health Information form.

I authorize Central Health to ***release/obtain*** (circle one) the following **protected health information** (PHI) from the medical record of:

Patient Name *(please print)* _____ Date of Birth _____ Last 4 of Social Security # _____

Address _____ Dates of Service _____

City _____ State _____ Zip _____ Phone Number _____

This information is to be *released to/obtained from* (circle one)**:**

Name: _____ Address: _____

City/State: _____ Zip:_____ Phone:_____ Fax:_____

Return Address for Central Health:

Name: _____ Address: _____

City/State: _____ Zip:_____ Phone:_____ Fax:_____

Please release/use/disclose the following protected health information in any form including verbal, written or electronic:

- ☐ All Health Information*
- ☐ Operative/Procedure Report
- ☐ Billing Records
- ☐ Medication Record
- ☐ Provider Notes
- ☐ X-Ray Images
- ☐ Diagnostic Report
- ☐ Immunization Record
- ☐ Office Visit Notes
- ☐ X-Ray Report
- ☐ Diagnostic Images
- ☐ External Records
- ☐ Provider Orders
- ☐ Lab/Pathology Results
- ☐ Diagnosis List
- ☐ Other _____

Your initials are required to release the following protected health information:

	INITIALS
☐ HIV Medical Information	_____
☐ Genetic Information	_____
☐ Substance Use Treatment Information** (including SUD Counseling Notes)	_____

***Describe how much and what kind of substance use disorder information may be disclosed, including an explicit description of the substance use disorder information that may be disclosed:*

_____

_____

_____

Please release my information via:

- ☐ Verbally
- ☐ Mail
- ☐ Pick-up
- ☐ Fax *(only for Providers or Emergency Purposes)*

Fax #: _____

Format:

- ☐ Electronic
- ☐ Paper

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Purpose of the Release:

☐ To coordinate my care ☐ Disability Benefits ☐ To give information about my treatment and services

☐ Attorney ☐ Patient is requesting disclosure

☐ Other (Please Explain): _____

The patient or the patient's representative must read the following statements:

I, the undersigned, understand that I may revoke this authorization at any time in writing by completing *Central Health's Revocation of Authorization to Release Protected Health Information Form* (or in writing to the disclosing entity if Central Health is the recipient of protected health information under this authorization), except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire 12 months from when it is signed unless otherwise specified (otherwise specified date:_____). All revocations must be sent to the Central Health return address listed above.

I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by Federal confidentiality rules.

I understand any of the above requested information may include results of sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) use and/or diagnosis and treatment of psychological disorders.

I understand that my information disclosed pursuant to this Authorization could be redisclosed by the recipient unless such redisclosure is expressly prohibited by other state or federal laws, and federal privacy laws may no longer apply to the information if the recipient is not subject to those laws.

I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

If this form is not complete Central Health may be unable to fulfill this request.

_____

SIGNATURE of Patient or Authorized Party Date **RELATIONSHIP** to Patient

_____

WITNESS **REASON** Patient is not signing

TO A PARTY RECEIVING SUBSTANCE USE RECORDS: *42 CFR part 2 prohibits unauthorized use or disclosure of these records.*