Texas Self-Directed Care

1199 S. Belt Line Rd. Ste. 100
Coppell, TX 75019
972-906-2813
Fax: 972-906-2834

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(Date) **(Participant Name)** **(DOB)** **(NorthSTAR ID #)**

Section A. I hereby authorize and give my permission to the providers/individuals listed below to release and/or receive a copy of my record:

☐ To send records **FROM:**

Name _____

Address _____

City/State/ZIP_____

Phone _____ FAX _____

☐ I give permission to those listed above to share and discuss my records.
☐ I give permission to those listed above to fax my records.
☐ **I give permission to release my records from the following dates**:

Start Date _____ End Date_____

☐ To give records **TO: Texas-Self Directed Care Program**

Section B. Purpose for this disclosure (check all that apply):

☐ Goal Planning
☐ Legal / Court / Corrections / Probation
☐ Eligibility Determination
☐ At the request of the client

☐ Other (specify): _____

Section C. RELEASE OF THE FOLLOWING RECORDS AND INFORMATION REQUIRES SPECIFIC AUTHORIZATION: I specifically authorize the voluntary release of the following medical records, if such records exist. I understand federal and state law protects them.

I hereby authorize release of specifically protected information regarding **drug and alcohol treatment services.**

_____ _____

Signature **Date**

Texas Self-Directed Care

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize release of specifically protected information regarding **legal and criminal history including any arrest.**

_____ _____

Signature **Date**

I here authorize release of specifically protected information regarding **higher level of care (e.g., crisis services, 23 hour observation, emergency care services, mobile crisis)**.

_____ _____

Signature **Date**

Section D. By ***INITIALING*** below, I specifically give permission to release the following records:

_____ Assessments / Evaluations
_____ Treatment / Service Plans
_____ Current Mental Status
_____ Progress Notes
_____ Medication Records
_____ Entire Record
_____ Abstract (Diagnosis, Treatment Plan, Assessments, Evaluations, current Medication Records, Psychiatric / Psychological Testing Reports)

_____ Laboratory Reports
_____ Psychiatric / Psychological Testing
_____ Academic Records / Progress
_____ Vocational Records
_____ Admission / Discharge Summary
_____ Financial / Billing Records

_____ Other (specify): _____

Section E. I understand I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. A revocation will not affect inspection of records necessary to validate expenditures by or on behalf of government entities. Unless revoked earlier, by CHECKING one box below this consent will expire:

☐ **180 days** from the date I sign
☐ for the period reasonably needed to complete the purpose of this request
☐ upon the **event** or **date** indicated: _____

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**

SIGNIFICANT INFORMATION: Information used or disclosed under this authorization may be subject to re-disclosure by others without your permission. In some instances, federal and state law may protect your information from being shared by others without your permission. In some instances, federal and state law may protect your information from being shared if it is HIV/AIDS information, genetic information, or drug/alcohol diagnosis, treatment, or referral information. If your written permission to release health information about you is needed to determine your eligibility for the TX SDC program, and you do not give us permission to release your health information, then you may not be able to show that you are eligible. If another health care provider has asked us to provide a health care service to you, such as a test or evaluation, and you do not give us your written permission to release your information to them, then we may not provide you with that health service.

TO THE RECIPIENTS OF PROTECTED HEALTH INFORMATION: The information disclosed to you by this authorization is protected by state law and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol and drug treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.