The Center for Health Care Services

AUTHORIZATION FOR DISCLOSURE, USE, OR RECEIPT OF PROTECTED HEALTH INFORMATION

Consumer Name: ______________________________

Case#: ______________________________

Program/Unit: ______________________________

Sub Unit #: ______________________________

Medicaid #: ______________________________

You have the right to refuse to sign this authorization. The Center for Health Care Services will not withhold treatment, Medicaid benefits, or payment processing if you refuse to sign the authorization. You will receive a copy of this signed authorization.

Date of Birth: ______________________ **Social Security Number:**__________________________________

I authorize the designated staff at The Center For Health Care Services to disclose/use/receive the following
(name of organization or individual)
protected health information about me (in any form, including verbal, written and electronic) for the time period of ____________ to _____________. Check all that apply:

- ☐ Physician/Medication Orders
- ☐ Lab/X-Ray Reports
- ☐ HIV/AIDS Information
- ☐ Nursing Notes
- ☐ Physician Progress Notes
- ☐ DMR/ CD&E Reports
- ☐ Counseling Notes
- ☐ ARD/IEP
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan/Treatment Reviews
- ☐ Alcohol/drug Abuse Treatment Information
- ☐ Discharge Summary
- ☐ Immunization Record
- ☐ Academic Record/Transcript
- ☐ Assessments: Psychological, Nursing, Speech-Language, OT/PT, Social, Educational, Vision, Hearing, & Vocational
- ☐ Other, specify and include dates: ____.

Are you requesting that a copy of these documents be sent to the individual/organization shown below? ☐ **Yes** ☐ **No**

The facility's designated staff may disclose to/receive from the following individual, organization or facility:
Name: ___________________________________ **Address:** ____

City: ________________________ **State:** _____ **Zip Code:** ________ **Fax #:** (____)__________ **Phone #** (___)_____________

The disclosure/use is for the following purpose(s):

- ☐ to coordinate my discharge/referral/placement
- ☐ to assist in educational placement/planning
- ☐ to assist with funding
- ☐ to assist in securing/maintaining employment/housing
- ☐ research
- ☐ to give information about my treatment and services
- ☐ at my request
- ☐ Other, state:____.

Note: If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.
Note: If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family.
You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the facility, except to the extent that the facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

Unless this authorization is revoked earlier it will expire 90 days from the date signed by the consumer or legally authorized individual, or as otherwise specified by date, event or condition of expiration: ____.

____ ______________________________
Signature of Consumer **Date**

____ _________________________ ____________________
Signature of Legally Authorized Individual **Relationship** **Date**

A photocopy or facsimile transmission is as valid as the original
(Note: For individuals receiving alcohol or drug abuse treatment, this form serves as the consent required by 42 CFR § S.31.)
Return completed form to: The Center For Health Care Services * Release of Information Dept. * 6800 Park Ten Blvd., Suite 200-S * San Antonio, Texas 78213 * Fax: (210) 261-1817 * Phone: (210) 261-1074