



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: _____ Phone #: (____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

I authorize the designated staff at The Center For Health Care Services to disclose/use/receive the following 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
- Physician Progress Notes
- Psychiatric Evaluation
- Discharge Summary
- Assessments: Psychological, Nursing, Speech-Language, OT/PT, Social, Educational, Vision, Hearing, & Vocational
- Lab/X-Ray Reports
- DMR/ CD&E Reports
- Treatment Plan/Treatment Reviews
- Immunization Record
- HIV/AIDS Information
- Counseling Notes
- Alcohol/drug Abuse Treatment Information
- Academic Record/Transcript
- Nursing Notes
- ARD/IEP
- 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 with funding
- research
- at my request
- to assist in educational placement/planning
- to assist in securing/maintaining employment/housing
- to give information about my treatment and services
- 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