Authorization to Release Protected Health Information

This form is used to request copies of records from or to release records to a 3rd party. Only patients or their legal representatives may make a request for records. Separate forms are required for each provider. Some requests may be subject to a fee. Please print clearly.

Part 1: Patient Information

Patient Name: ____ **Date of birth:** _____________

Phone: _________________________________ **Alternate Phone:** ________________________________

Address: ____

City: ____ **Zip code**: ________________________

Part 2: What information is being requested? (Mark all that apply)

Date(s) of service being requested: _______________________ **Check Here ☐ if Dates of Service include entire period that child is receiving care from agency.**

☐ Evaluations
☐ Journal Notes
☐ Visit Notes
☐ Discharge Docs.
☐ Billing (Claims)
☐ Admission Docs.
☐ Plan of Care
☐ Social Work Records
☐ Other(Specify)_______________
____

Part 3: Purpose of Disclosure: (Select only one box)

☐ Billing or Claims
☐ Care Coordination
☐ Treatment/Continuing Medical Care
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ Obtain a copy of health information
☐ Other (Specify)_________
____

Part 4: Third Party Information

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:
Check Here ☐ If Green Apple Therapy is the Disclosing Agency

Person/Organization Name ____
Address ____
City ____ State ________ Zip Code _____________________
Phone (_______)____________________ Fax (_______)____________________

WHO CAN RECEIVE AND USE THE PROTECTED HEALTH INFORMATION?
Check Here ☐ If Green Apple Therapy is the Receiving Agency

Person/Organization Name ____
Address ____
City ____ State ________ Zip Code _____________________
Phone (_______)____________________ Fax (_______)____________________

Part 5: Terms of Authorization

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):
Month _________ Day __________ Year _________

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature:____Date: ________________________

Printed name:____________________________________Relationship to patient: _________________