# 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:** ________________________________

**Street Address**: ________________________________________________________________________

**City**: __________________________________________ **Zip code**:________________________

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

**Date(s) of service being requested**:__________________________________________________________

- ☐ Evaluations
- ☐ Chart Notes
- ☐ Visit Notes
- ☐ Discharge Docs.
- ☐ Billing (Claims)
- ☐ Admission Docs.
- ☐ Plans of Care
- ☐ All Therapy Records
- ☐ Social Work Records
- ☐ Other _______________

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

- ☐ Billing or Claims
- ☐ Care Coordination
- ☐ Treatment/Continuing Medical Care
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ Other _________________

## Part 4: Third Party Information

**I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:**

Person/Organization Name ______________________________________________________________
Street Address ______________________________________________________________________
City ____________________________________ State ________ Zip Code __________
Phone (_______)___________________ Fax: _________________________ Email: _____________________________

**WHO CAN RECEIVE AND USE THE PROTECTED HEALTH INFORMATION?**

Person/Organization Name ______________________________________________________________
Street Address ______________________________________________________________________
City ____________________________________ State ________ Zip Code __________
Phone (_______)___________________ Fax: _________________________ Email: _____________________________

## 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earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):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: ______________________