AUTHORIZATION FOR RELEASE OF
MEDICAL/PSYCHIATRIC/SUBSTANCE ABUSE - ARREST/CRIMINAL - CORRECTIONAL/PROBATION/PAROLE
SCHOOL/ EDUCATIONAL - LITIGATION - EMPLOYMENT/INCOME - RECORDS AND INFORMATION

DIRECTED TO: _____

"I, _____ , do hereby **Authorize the Release of any form of records, including all MEDICAL___, PSYCHOLOGICAL___, PSYCHIATRIC___, SUBSTANCE ABUSE___** information, including any and all records that may be protected by 42 CFR part 2, (including copies) contained in reports, evaluations, testing, assessments, histories, examinations, notes, prescriptions___ , admission/discharge documents, treatment plans and instructions, limitations or any other form of document relating to the diagnosis and/or treatment of any real or suspected conditions, including, but not limited to medical, psychiatric, psychological, substance abuse, **HIV/AIDS and sexually related disorders___**, which is under your care, custody or control, pertaining to myself or any other person for whom I may legally consent. I further Authorize any Service Providers, Record Holders, or other persons who have created, assisted in the creation of, or held, the above records or the information contained therein to engage in **open communication** with my attorney(s) or their representatives as listed below."

"I, _____, do hereby further **Authorize the Release of any form of MENTAL HEALTH/MENTAL RETARDATION RECORDS___** held by any regional or state branch of Texas MHMR, or similar organizations in other states, including reports, evaluations, testing, assessments, histories, examinations, notes, prescriptions, admission/discharge documents, treatment plans and instructions, limitations or any other form of document relating to the diagnosis and/or treatment of any real or suspected conditions, including, but not limited to medical, psychiatric, psychological, substance abuse, **HIV/AIDS and sexually related disorder___**, which is under your care, custody or control, pertaining to myself or any other person for whom I may legally consent. I further authorize any staff member of MHMR to discuss any aspect of the above with members of my defense team listed below."

"I, _____, do hereby further **Authorize the Release of any form of ARREST or CRIMINAL RECORDS**, documents, data, reports, offense information (reports, summaries, records, statements, documents, notes), case file documents and /or reports or any other form of information pertaining to my present and/or past criminal history, adult and juvenile, specifically including any document showing my present and/or past alleged or proven criminal conduct that may come into view as a result of criminal records check performed by any law enforcement agency located in the United States, the State of Texas or any other state in the United States."

"I, _____, do hereby further **Authorize the Release of any form of CORRECTIONAL or PROBATION and/or PAROLE RECORDS** or information in the possession of any **community, city, county, state or federal penal institution, including juvenile facilities** medical facilities, mental health facilities and any court or **probation or parole department**. It is my intention that this authorization include any and all information contained in my Unit File, Classification File, Travel Cards, Grievance Files, Incident reports, Disciplinary Reports, School Records, Gang Classification Files, or Probation/ Parole Case or Supervision File, Medical Service File, Counseling or other Treatment file."

"I, _____, do hereby further **Authorize the Release of any and all LITIGATION or ATTORNEY** files, records, and materials concerning my **representation in any and all criminal or civil matters**, whether pending or closed. I also expressly waive my Attorney-Client privilege and authorize my former attorney to discuss and give information regarding any aspect of his representation to my attorney or attorney representative listed below. This release covers all materials in the possession of my attorney and/or his agents including, but not limited to: all files, memoranda, records, (including medical, psychiatric, substance abuse, school, employment, criminal, and military records); statements by witnesses or myself; whether given orally, taped or in writing; and notes (including investigative and research notes) and notes of meetings and telephone conversations concerning my representation."

"I, _____, do hereby further **Authorize the Release of any and all INSURANCE INFORMATION**, whether health, life, car, or otherwise in nature, including all claims, policies, and payments."

"I, _____, do hereby further **Authorize the Release of any form of INCOME OR EMPLOYMENT Records**, documents, data, reports, evaluation, accident or incident information (reports, summaries, records, statements, documents), employment file documents and/or reports or any other form of information pertaining to my present and/or previous **employment history,** unemployment, worker's compensation, Social Security and earnings information, Tax records or filings submitted to any State or Federal Internal Revenue Service or tax office."

"I, _____, do hereby further **Authorize the Release of any form of SCHOOL or EDUCATIONAL Records**, documents, data, reports, disciplinary information (reports, summaries, records, statements, documents) case file documents, Testing, Assessments, Evaluations and academic transcripts, Conference notes, or any other form of information pertaining to my present, and/or past educational activities."

Purpose: These records are being requested in order to assist an Attorney in preparation of a legal matter.

Revocation: This request is subject to revocation at any time except to the extent that the program or person that is to make the disclosure has already acted in reliance on it. In any event, this consent will expire 730 days after the date signed below.

Such records should be released immediately upon request by and to Attorney(s), _____, ___; or their representative(s), _____ and/or _____ and/or _____, ___; where such records shall continue to be confidential until and unless I give my written consent for them to be released to any other person. Any responsive records may be released to the previously listed individuals or their designees upon presentation of a copy or a facsimile copy of this release. I understand that once delivered, the confidentiality of the released records cannot be ensured by the releasing party. Additionally, I am aware that I may refuse to sign this release and that any services that I am to be provided are not and cannot be conditioned on my signing of this release. Documents and information obtained by this request may be subject to re-disclosure by the recipient and no longer protected by the HIPAA Privacy Regulations."

Client Printed Name: _____ Client Date of Birth: _____

LAR (if applicable) Printed Name: _____ Client SSN: _____

Client/LAR Signature: _____ Date: _____

STARCARE
SPECIALTY HEALTH SYSTEM

AUTHORIZATION & CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize StarCare Specialty Health System to ☒ Release ☒ Exchange ☒ Receive information concerning the person/patient noted below:

Person/Patient Name (Print)	Date of Birth	SS# or Case Number	Medicaid #

Date(s) of Service (if known): _____

I hereby authorize StarCare Specialty Health System to release information or records ☒ To ☒ With ☒ From:

Name of Person or Organization:		**Area Code and Phone Number:**	
Lubbock Private Defenders Office		(806)749-0007	
Street Address:	**City:**	**State:**	**Zip Code:**
1401 Crickets Ave.	Lubbock	TX	79401

Effective Time Period of Authorization:

I understand this authorization will **expire one (1) year** from the date of this authorization unless I specify otherwise.
I desire this authorization to be in effect until the following date (optional) _____.

Information to be Released: (check minimum necessary for purpose)

☒ Psychological Evaluation	☒ Physician Orders	☒ Social History	☒ HIV Information
☒ Psychiatric Evaluation	☒ Treatment Notes	☒ Diagnosis	☒ Substance Use
☒ Treatment/Care Plan	☒ Discharge Summary	☒ Medications	☒ Lab Reports
☒ Complete Medical Record	☒ Assessments	☒ Medical History	☒ Financial/Billing
☐ Other: (please specify)			

Purpose of Disclosure: (check only what is applicable)

☐ Person/Patient or LAR Request	☐ Medication Verification	☒ Legal
☐ Benefit Eligibility Verification	☐ Continuity of Care	☐ Aid in Treatment Planning
☐ Financial/Insurance Verification	☐ Other: (please specify)	

Type of Disclosure: (check all that apply)

☐ Paper Copy	☒ Electronic Copy	☐ Verbal	☐ Review Only	☐ Mail	☒ Pick up

Right of Refusal to Sign:

I understand this authorization is voluntary and I may refuse to sign. I further understand my healthcare and the payment of my healthcare will not be affected if I do not sign this form.

I understand if the recipient authorized to receive this information is not a covered entity as defined under federal privacy regulations, the disclosed information, except chemical/alcohol dependency information, may no longer be protected by federal privacy regulations.

Revocation of Authorization:

I understand I may **revoke** this authorization at any time by notifying StarCare's Release of Information (ROI) Specialist in writing (address noted below). I also understand the written revocation must be signed and dated later than the date of this authorization. The revocation will not affect any actions taken before the receipt of my written revocation. Any information released prior to receipt of the revocation is considered to have been released with my full consent.

x		x
Person/Patient or LAR Signature	Date	Printed Name
x		
Witness Signature	Date	LAR Relationship to Person/Patient (if applicable)

LUBBOCK PRIVATE
DEFENDERS OFFICE

Informed Consent

1. Purpose-The purpose of the Lubbock Private Defenders' office's mental health program is to make every effort to connect me to community services and agencies which treat mental illness and to help people who are indigent by offering resources, referrals and coordination of services.
    a. Goal: to help me transition from the jail into the community, and for me to be referred to resources to meet my needs. Also, to reduce the likelihood that I will be involved in the criminal justice system again.
    b. Techniques-This is a non-therapeutic relationship, and no therapeutic techniques will be used by my case manager.
        i. Some psychoeducational and coordination services will be provided.
        ii. I will be encouraged by my case manager to take medications if they are prescribed to me.
        iii. I will be referred to therapeutic resources, and resources that can provide holistic treatment and services that serve those who are indigent.
    c. Restrictions-If the case manager holds a professional license the license is currently in good standing with the respective board and the board has not imposed any restrictions on their license.
    d. Confidentiality limits-I understand that any personal information, medical information, and historical data I submit to the LPDO will remain confidential unless I authorize disclosure. The only exceptions are in the following circumstances:
        i. Your Attorney- He or she will have access to all of the case management notes and will have full access to any information collected by the case manager. He or she will speak regularly with your case manager regarding your case.
        ii. I waive the right to confidentiality in the event that the information is court ordered.
        iii. If it is court ordered for me to have an examination by a Psychologist, I authorize my Attorney and/or my mental health case manager to provide records to the Psychologist. The records provided will include: records relative to my legal case, (police reports, discovery, indictment, the range of punishment for the crime I am charged with etc.) and 3rd

party medical and mental health records needed for the purpose of the exam.

iv. If at any point you are court ordered to have a Guardian, third party medical and mental health records collected on your behalf by this office, can be released to: the Guardian, Guardian Ad Litem, or Attorney Ad Litem who represent your best interest.
v. Starcare staff
vi. Information needed for county billing and reports
vii. By signing below I acknowledge that Attorney client privilege and or counselor client privilege is waived in the event that my case manager is asked to testify in court.

2. I have been informed that I am being offered assistance from the Lubbock Private Defenders' Office, in addition to what my Attorney provides, in the form of mental health case management services.
3. Mental health case management services are being offered free of cost to me. There may be court costs that I will be responsible for, but this is not related to the mental health case management services I am provided.
4. I have been informed that my participation in case management services is voluntary. I have the right to decline further assistance from the program at any point.
5. Case Management will conclude approximately 1 month after the legal case is disposed.
6. My mental health case manager is required to notify the appropriate authorities if he or she has a suspicion, or becomes aware that I am intending to harm myself or someone else. In the event that there is a suspicion that someone is harming or will harm me, my case manager is obligated to report this to Adult Protective Services.

I have had the opportunity to ask questions about the nature, scope, and purpose of the LPDO mental health program. By signing below, I am affirming my participation in this process is voluntary, and that I agree with all of the objectives of this informed consent document.

Client's signature: _____ Date: _____

Client's Printed Name:_____

LPDO Case Manager: _____ Date: _____

	Release of Information	Patient Name (Last, First, MI):
Date of Birth:	Status: ☐ Adult ☐Juvenile	Patient ID No:	Date

I Authorize / Autorizo:	To Release Information To / A divulgar Información a:
Name of organization or individual / Nombre TTHSC	Name of organization or individual / Nombre Lubbock Private Defenders Office
address / Dirección 3502 N Holly Ave LUBBOCK, TEXAS 79403 P.O. BOX 10536 LUBBOCK, TEXAS 79408 PHONE # 806-775-7108 FAX # 806-775-7118	Address / Dirección 1401 Crickets Ave, Lubbock, TX 79401

1 This authorization includes records relating to the following (please check) / La presente autorización comprende los registros relacionados con lo que se detalla a continuación (por favor, marque la opción correcta):

☒ All remaining records / Otros registros restantes ☐ ✕Specify / Especificar _____
☒ Mental health treatment / Tratamiento de salud mental
☒ Chemical dependency treatment / Tratamiento de drogadicción o alcoholismo
☒ HIV or AIDS related tests and treatment / Tratamiento o pruebas de SIDA o VIH

2 Purpose for disclosure (this line must be completed) / Propósito de la divulgación (se debe completar este renglón):_____

CONTINUITY OF CARE

3. Indicate dates of interest / Indique las fechas importantes. _____
If no date-range is provided, release will cover the previous year only / Si no se indica el periodo de divulgación, la misma tendrá lugar sólo por el término del año anterior.

4. I understand that I may revoke this authorization at any time by providing written notice, except to the extent that release of information has already occurred in reliance upon it.

5. I understand that under Federal Law (42 CFR Part 2) records relating to treatment for chemical dependency cannot be released without my specific authorization as indicated under "1."

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

7. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned upon whether I sign this Release of Information.

8. I agree to hold harmless all persons acting upon this authorization in good faith.

9. It is my intention that a photocopy will be as valid as this original.

10. **This authorization shall be valid for one year from the date of my signature.**

4. Comprendo que puedo revocar la presente autorización en cualquier momento siempre que notifique mi decisión por escrito, salvo que la divulgación de mi información se haya efectuado dependiendo de dicha autorización. 5. Comprendo que conforme a la Ley Federal (42CFR – Código de Normativa Federal – Parte 2) los registros relacionados con el tratamiento para el alcoholismo o drogadicción no pueden divulgarse sin mi previa autorización específica tal como indica el punto "1."

6. Entiendo que la información utilizada o revelada conforme a esta autorización puede ser divulgada por el destinatario y ya no estar protegida bajo ley federal o estatal

7. Comprendo que mi tratamiento, pago, o elegibilidad de beneficios no esta condicionados a mi firma que consentira el acceso de la información. pertinente. 8. Acepto eximir de responsabilidad a todas las personas que actúen con buena fe bajo la presente autorización. 9. Manifiesto que una fotocopia tendrá el mismo valor que su copia original.

10. **La presente autorización tendrá validez por el plazo de un año a partir de la fecha de mi firma.**

Patient or authorized signature / Firma del paciente o persona autorizada	Date / Fecha
If other than patient signature, relationship to patient / Si no es la firma del paciente, indicar relación con el paciente	Date / Fecha
Witness signature / Firma del testigo	Date / Fecha

PATIENT NAME:_____ Date of Birth:_____
MEDICAL RECORD NO._____ SOCIAL SECURITY NO._____
ACCOUNT # _____
TREATMENT PERIOD FROM_____ TO _____

Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide to designated parties all information requested may invalidate this Authorization and your information may not be disclosed.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: Covenant Health System
to release to: Lubbock Private Defenders Office
1401 Crickets Ave Lubbock TX 79401 806-749-0007
(Persons/Organization authorized to receive the information (Address - street, city, state, zip code (as applicable the following information):

a. ☒ All health information pertaining to my medical history, mental or physical condition and treatment received - ***OR***
☐ Only the following records or types of health information (including any dates):
_____

b. I specifically authorize release of the following information (check as appropriate):
☒ Mental health treatment informaiton[1]
☒ HIV test results
☒ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure: ☐ patient request; ***OR*** ☒ other:
Legal Defense

EXPIRATION

This Authorization expires [insert date or event][2]:_____

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[3]

[1]If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to third party by the patient, the physician licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

[2]If authorization is for use or disclosure of protected health information for research, including the creation and maintenance of a research database of repository, the statement "end of research study," "none".

I may inspect or obtain a copy of any health information that is release pursuant to my signing of this authorization.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: _____. My intent to revoke this authorization will take effect upon receipt of my written request, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.[4]

COVENANT HEALTH SYSTEM
LUBBOCK, TEXAS
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

7503-55* 07/08 Graphic Communications

COVENANT HEALTH SYSTEM

LUBBOCK, TEXAS

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Some re-disclosures may not be protected by California law, or by the federal confidentiality law referred to as the Health Insurance Portability and Accountability Act (HIPAA).

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.[5]

SIGNATURE

Date:_____ Time:_____am/pm

Signature:_____

(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Witness:_____

[3]If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[4]Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 C.F.R. Section 164.5078(d)(I), (e)(2)).

[5]The requestor is to complete this section of the form.

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

PO Box 5066, 3601 4th St., 1B108
Lubbock, TX 79430-5066
806-743-2608
1-888-300-9868 Toll Free

Authorization to Release and Disclose Patient Information

PATIENT INFORMATION TTUHSC MRN:_____	PATIENT NAME: _____ DATE OF BIRTH:_____ Address:_____ Day Phone:_____ City:_____ State:_____ Zip:_____
RECEIVING PARTY ☑ **Send** the information to: ☐ **Receive** the information from:	NAME:LUBBOCK PRIVATE DEFENDERS OFFICE Address:1401 Crickets Ave Phone:806-749-0007 City:LUBBOCK State:TX Zip:79401
INFORMATION TO BE RELEASED (**What** do you want sent or **released**? Check the appropriate box.)	☑ Any and All records (complete record) **Only records types checked below:** ☐ Progress notes/clinic notes ☐ Schedule ☐ Laboratory reports ☐ Other (please specify)_____ ☐ Immunization record ☐ Billing Records (dates) _____ ☐ Medication record ☐ Routine Record Set (indicate date(s) of service_____) (office visit, lab, radiology, medicines, immunizations) **I agree that the following information may be released/used only as indicated below:** 1. AIDS/HIV test results, diagnosis, treatment, and related information Yes✓ No___ 2. Drug screen results and information about drug and alcohol use and treatment Yes✓ No___ 3. Mental health information Yes✓ No___ 4. Genetic testing Yes✓ No___
RELEASE INSTRUCTIONS (**How** do you want the information?)	☑ Electronic Form (CD/USB preferred method) ☐ Paper
PURPOSE OF RELEASE (Why is it needed?)	☐ Continuing Care by other health care provider ☐ Disability ☐ School ☐ Insurance ☐ Personal review ☑ Attorney/Legal ☐ Other_____
To The Receiving Party Of This Information	This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation. Federal rules prohibit you from further disclosure unless you have received written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

- This authorization is voluntary and I may refuse to sign it. My treatment or payment for services will not be affected if I do not sign this Authorization.
- This Authorization may be canceled by submitting a written notice to Texas Tech University Health Sciences Center (or the releasing facility). Information may be released until my written notice of cancellation is received.
- **This Authorization expires 180 days from the date signed or on the following date or event (specify)** 1 YR FROM SIGNAURE DATE
- Additional information is in TTUHSC's Notice of Privacy Practice.
- If the healthcare services are being provided at the request of and being paid for by my employer (or prospective employer), I understand and agree that all records and information related to the healthcare services provided to me may be given directly to my employer and if I wish to obtain such information, I must contact my employer/prospective employer.

RELEASE FROM LIABILITY: I release and agree to hold harmless TTUHSC Clinic (or other releasing facility) and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with the Authorization. I understand TTUHSC Clinic (or the releasing facility) cannot be responsible for use or rediscover of information to third parties.

I certify that this form has been fully explained to me, I have read it or had it read to me*, and I understand its contents.

Date _____ Print Your Name **(Person signing consent form)** _____ Patient or Legally Authorized Signature _____

Time _____ Witness/Translator * _____ Relationship to patient SELF

UMC HEALTH SYSTEM
UNIVERSITY MEDICAL CENTER
602 INDIANA AVENUE
LUBBOCK, TEXAS 79415

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

IDENTITY OF PATIENT

UMC RELEASE OF INFORMATION
Office 806-775-9150, Fax 806-775-9157

Patient Name: _____ Date of Birth: _____

Address: _____ Med Rec #: _____

_____ Visit #: _____

Email Address _____

WHO MAY MAKE THE DISCLOSURE

I request and authorize the following entity and its employees and agents to release information relating to the diagnosis, care, and treatment of the above-named patient:

University Medical Center; 602 Indiana Avenue; Lubbock, TX 79415

TO WHOM THE DISCLOSURE MAY BE MADE

If requesting that requested records be faxed, please remember to include return fax number below.

Name: Lubbock Private Defenders Office Name: _____

Address: 1401 Crickets Ave, Lubbock, TX 79401 Address: _____

Phone: _____ Phone: _____

Fax: 806-794-0009 Fax: _____

WHAT INFORMATION TO DISCLOSE

The type and amount of information to be used or disclosed is as follows:
Check appropriate item(s) and include other information where indicated.

☒ All Medical Records _____

☐ Medical Records from _____ (date) to _____ (date)

☐ Other (please specify): _____

_____

I understand that information in my health record may include information relating to:
(1) AIDS/HIV test results, infection status, or treatment information; (2) sexually transmitted disease; (3) treatment for alcohol and drug abuse; (4) behavioral and mental health services; (5) Genetic Testing.

I AUTHORIZE THE DISCLOSURE OF THIS INFORMATION EXCEPT AS FOLLOWS:

All medical records

_____

_____

PURPOSE OF DISCLOSURE

This information is being released for the following purpose(s):

☐ Continued care by other health care provider ☐ School

☒ Attorney ☐ At the request of the individual

☐ Insurance ☐ Personal Review

☐ Disability Determination ☐ Other: _____

UMC HEALTH SYSTEM
UNIVERSITY MEDICAL CENTER
602 INDIANA AVENUE
LUBBOCK, TEXAS 79415

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

TERMS OF DISCLOSURE

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to:

Records Custodian, Health Information Management
University Medical Center
602 Indiana Avenue
Lubbock, TX 79415

I understand that the revocation will not apply to information that has already been released in response to this information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

If I fail to specify an expiration date, event, or condition, this authorization will expire 180 days from the date of signing.

I have read this form and agree to the uses and disclosures of the information as described.

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that I need not sign this order to ensure health care treatment.

I fully understand and accept the terms of this authorization.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE	DATE	TIME

PRINT NAME OF REPRESENTATIVE (IF APPLICABLE)	REPRESENTATIVE RELATIONSHIP TO PATIENT

OFFICE USE ONLY

☐ Authorization verified by _____ on _____ (date)
☐ Patient has been provided with a copy of the signed authorization.

RIVER CREST HOSPITAL – HEALTH INFORMATION MANAGEMENT
PHONE # 800-777-5722 FAX # 325-223-7318
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Current Phone #: _____
Current Address: _____ Last 4 of SS#: _____

To be released to or requested from:

☐ Self (address above)

☒ Lubbock Private Defender Office (___) _____ 1401 Crickets Ave
Individual/Agency/Organization Telephone Number Street Address

Legal Defense (806) 749-0009 Lubbock TX 79401
Relationship to Patient Fax Number City State Zip Code

Via (only when released to): ☐ Mail ☐ Fax ☐ Pick-up ☒ Email: _____
☐ Verbal Exchange of Information ONLY

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☒ Legal Investigation ☐ Billing/Insurance ☒ Other: Legal Defense

Dates of Service Requested: _____

☒ **I authorize the release of the following information including all records that include any substance use disorder and/or substance use disorder treatment records,**

OR

☐ **I authorize the release of the following information excluding all records that include any substance use disorder and/or substance use disorder treatment records,**

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☒ Continuity/Transition of Care Packet
☒ Psychiatric Evaluation
☒ History and Physical
☒ Discharge Summary
☒ Progress Notes
☒ Physician Orders
☒ Lab/Diagnostic Reports
☒ HIV Test Results and AIDS Treatment Records
☐ Other: _____

This authorization will expire on ___/___/20___. (If not indicated, authorization will expire one year from signature date)
This form must be completed in full before signing:

_____ _____
Patient's signature (required for ages 16 and older) Date/Time Signed

_____ _____ _____
Parent/Legal Guardian signature (if applicable) Relationship to Patient Date/Time Signed

_____ _____
Witness signature/Credentials Date/Time Signed

This authorization is intended to allow River Crest Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

_____ _____
Revocation Signature Date/Time

WHITE – CHART **YELLOW – HEALTH INFORMATION MANAGEMENT**

Oceans

Authorization for Disclosure of Health Information

I hereby authorize _____ **to release medical information from the records of:**

(Name of Facility)

Patient Name: _____ **D.O.B** ___/___/___ **SS#: XXX-XX-** ____

(MM/DD/YYYY)

Patient Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date(s) of Treatment Requested: _____

Information to be disclosed (check all applicable items to be released):

☐ Medical Records	☐ History and Physical	☐ X-Rays Reports	☐ Progress Notes	☐ Commitment Papers
☐ Billing Records	☐ Consultations	☐ Lab Reports	☐ Medication Records	☐ Treatment Plans
☐ Discharge Summary	☐ Operative Report	☐ EKG/ECG Tests	☐ HIV testing	☐ Doctor's Orders
☐ Discharge Instructions	☐ ER Record	☐ Therapy Notes	☐ Nurse's Notes	

☐ Other (please specify): _____

Purpose Or Need For The Disclosure Is:

☐ Continued Medical Care ☐ Insurance ☐ Legal ☐ Patient's Own Use ☐ Other _____

The Information May Be Disclosed To:

Recipient's Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Fax#:** _____

Preferred Deliver Method: ☐ **Email** _____ ☐ **Paper** ☐ **CD**

(If no method is specified records may be sent on either paper or CD depending on number of pages reproduced.)

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ **or upon the following event:** _____

(Date)

(If no date or event is specified, this authorization will expire one (1) year from the date of signature.)

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

_____ _____

(Signature of Patient or Personal Representative)* *(Date of Signature)*

***If signed by a personal representative, a description of the representative's authority to act is as follows:**

☐ Parent ☐ Legal Guardian ☐ Health Care Power of Attorney ☐ Administrator ☐ Executor of Estate ☐ Next of Kin ☐ Beneficiary

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