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 MAIN: 806-749-0007 FAX: 806-749-0009

(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:
ASSIST WITH A LEGAL MATTER

EXPIRATION

This Authorization expires [insert date or event][2]: 1 YEAR FROM SIGNATURE DATE

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.