TEXAS Health and Human Services

Texas Department of State Health Services

Authorization for Disclosure, Use, or Receipt of Protected Health Information

(Note: For individuals receiving alcohol or drug abuse treatment, this form serves as the consent required by 42 CFR § 2.31.)

You have the right to refuse to sign this authorization. We 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.

Individual: _____ MPI/Case No. : _____ DOB: _____

I authorize the staff at **North Texas State Hospital**
(name of organization or facility)

to disclose/receive the following protected health information about me: **MY ENTIRE RECORD FROM MY ENTIRE TIME I WAS A PATIENT AT THE HOSPITAL TO INCLUDE BUT NOT LIMITED TO: INTAKE FORMS, EXAMS; PROGRESS NOTES; ALL ASSESSMENTS; QUIZZES, DIRECT CARE STAFF NOTES, INCIDENT REPORTS, TREATMENT TEAM MEETING NOTES, MEDICATION ORDERS;**
(describe the specific types of information, including time period covered)

The staff may disclose **to/**receive from: **( ) AND/OR their representative from the LUBBOCK PRIVATE DEFENDERS' OFFICE 1401 Crickets Ave. LUBBOCK TX 79401 Main: 806-749-0007**

Email of person requesting record: ( ) Fax: 806-749-0009
(name/address/phone number of person, organization, or facility – **one couple or person/agency/organization per form**)

(relationship)

☒ Correspondent ☐ Parent ☐ Guardian ☐ Emergency Contact ☐ Next of Kin
(contact as – select **ONE**)

The disclosure/use is for the following purpose(s):

☐ to coordinate discharge planning/placement
☒ at my request
☐ to discuss with my family the care and treatment I receive at _____
☒ other: **TO ASSIST WITH INDIGENT LEGAL DEFENSE SERVICES**
☐ to assist in educational placement
☐ to assist in additional funding

I also authorize the disclosure/use/receipt of my health information regarding: ☒ HIV/AIDS ☒ Mental Health Records ☒ alcohol and drug abuse treatment

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 organization or 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 organization/facility, except to the extent that the organization/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 on: **10 years from date of signature**
(date, event, or condition of expiration)

X	Self	
Individual Patient or LAR signature	Relationship to Patient	Date
Witness(es) or if patient unable/unwilling to sign/date form but gives verbal consent		Date

REVOCATION/WITHDRAWAL OF AUTHORIZATION FOR DISCLOSURE

Date of Revocation/Withdrawal	Time of Revocation/Withdrawal	
Signature of person requesting withdrawal	Relationship to Patient	Date
Signature of Witnesses if patient unable to sign revocation/withdrawal		Date