

Authorization to Disclose Protected Health Information (or other confidential information)

This authorization complies with the requirements of §164.508 of the HIPAA Privacy Standards (45 CFR, Parts 160 and 164)

Name: _____
(Name of Individual)

Address: _____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

Date of Birth: _____
(Of Individual)

I authorize the following person or entity:

Department of State Health Services

(Specify the Individual, Physician, Hospital, Clinic, Attorney, Counselor, School, Governmental entity, etc.)

1100 West 49th Street Austin TX 78756
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

To disclose the following specific protected health or other confidential information:

Yes () No () Medical or Health Information. Indicate specific information: Newborn Screen

If yes, please provide Mother's first and last name: _____

Yes () No () HIV-Related Information. Indicate specific information: _____

Yes () No () Psychological Reports. Indicate specific information: _____

Yes () No () Social History. Indicate specific information: _____

Yes () No () Other. Indicate specific information: _____

To the following individual or entity:

(Name or Position of Individual / Entity authorized to receive information)

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

The information disclosed may be used by the individual or entity receiving the information for the following purpose(s):

I understand that: 1) I may revoke this authorization in writing by contacting the DSHS office or program that obtained the authorization; 2) this authorization will not affect treatment, payment, enrollment, or eligibility for benefits; and 3) information disclosed as a result of this authorization could be subject to re-disclosure as authorized by law.

EXPIRATION DATE: This authorization will expire on [date or event] _____
(If no date or event is stated, expiration is one year from the date it is signed.)

This form () was read by me () was read to me and I understand its purpose and content. All blanks were completed or struck through before I signed the form.

Signature of Individual or Parent of Individual of minor Date signed

(Print / Type Name of Personal Representative state their authority to act to act on behalf of individual. Attach documents to support authority)

(Signature of Personal Representative)

(Address) (Telephone)

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us/> for more information.

Autorización para divulgar información confidencial

Nombre: _____
(Nombre del cliente)

Dirección: _____
(Calle y número, apartado postal, número de Rt. #) (Ciudad) (Estado) (Código Postal)

Fecha de nacimiento: _____
(de individuo)

Autorizo a la siguiente persona o entidad

(Individuo, médico, hospital, clínica, abogado, consejero, escuela, etc.)

(Calle y número, apartado postal, número de Rt. #) (Ciudad) (Estado) (Código Postal)

A divulgar información específica protegida u otra información confidencial:

Sí () No () Información médica o de salud. Indique información específica:

Newborn Screen: _____

En caso afirmativo, por favor proporcione madre primero y apellidos: _____

Sí () No () Información sobre el Virus de Inmunodeficiencia Humana (VIH). Indique información específica:

Sí () No () Reportes psicológicos. Indique información específica:

Sí () No () Historial social. Indique información específica:

Sí () No () Otra información. Indique información específica:

al siguiente individuo o entidad:

(Nombre o posición del individuo, de la organización, si acaso representa a alguna)

(Calle y número, apartado postal, número de Rt. #) (Ciudad) (Estado) (Código Postal)

La información divulgada podría ser usada por el individuo o, por la organización que el individuo representa, para los siguientes propósitos:

Yo entiendo que: 1) yo podría revocar por escrito esta autorización poniéndome en contacto con la oficina o programa de DSHS que obtuvo la autorización; 2) esta autorización no afectará el tratamiento, pago, inscripción o, la elegibilidad para los beneficios y; 3) la información que se divulgue como resultado de esta autorización podría divulgarse nuevamente de acuerdo a la ley.

FECHA DE VENCIMIENTO: Esta autorización se vencerá el [fecha o evento] _____
(si acaso no se declara fecha o evento, expira al año de la fecha en que fue firmada.)

Este formulario () yo lo leí () se me leyó y, entiendo y acepto su significado. Todas las líneas en blanco fueron llenadas, antes de que yo firmara este formulario.

Firma

(Escriba en letra de molde o con máquina de escribir el nombre de la persona autorizada para acceder la divulgación de la información)

(Firma de la persona autorizada)

(Dirección) (Número de teléfono) (Fecha)

NOTIFICACIÓN SOBRE PRIVACIDAD

Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a <http://www.dshs.state.tx.us/> para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code*, sección 552.021, 552.023, 559.003 y 559.004)

Instructions for Obtaining Consent to Release Medical Information

Information contained in client records is confidential. With certain exceptions, the release of medical records is prohibited by the provisions of the Medical Practice Act (Article 4495b, V.T.C.S.). In addition, social, financial, educational and other types of information in client files may be protected by a constitutional or common law right to privacy. There are civil and criminal penalties for the unauthorized release of such information.

The Medical Practice Act, the common law and the Constitution permit a health care provider to release these types of information from an individual's record with the consent of the individual or a person authorized to consent for the individual. For example, the Medical Practice Act states:

Occupations Code Sec. 159.005(a)(1-5) and (b). Consent for the release of confidential information must be in writing and signed by the patient, or a parent or legal guardian if the patient is a minor, or a legal guardian if the patient has been adjudicated incompetent to manage his personal affairs or an attorney ad litem appointed for the patient, as authorized by the Texas Mental Health Code; the Persons With Mental Retardation Act; Chapter XIII, Texas Probate Code, and Subtitle B Title 5, Family Code; or a personal representative if the patient is deceased, provided that the written consent specifies the following:

- (A) the information or medical records to be covered by the release;
- (B) the reasons or purposes for the release; and
- (C) the person to whom the information is to be released.

Further, the Communicable Disease Prevention and Control Act (Chapter 81, Health and Safety Code) contains the following specific requirements for the release of information relating to tests for AIDS, the human immunodeficiency virus (HIV), and antibodies to HIV:

Sec. 81.103(d). An Authorization under this subsection must be in writing and signed by the person tested or the person legally authorized to consent to the test on the person's behalf. The authorization must state the person or class of persons to whom the test results may be released or disclosed.

The "Authorization to Release Confidential Information" form was developed to conform to these statutory requirements. For this reason, when you are requested to release information from records under your control, the form must be carefully completed to provide the information required by statute. If you are requested to provide information from a client record to an institution (e.g., a hospital) rather than an individual, and you do not know the name of the individual within the institution to whom the information is to be sent, insert the title of the responsible person (e.g., the administrator, medical records librarian, etc.). Do not simply insert the name of the hospital.

The "Authorization to Release Confidential Information" form must be completed and signed by individual clients when they request their personal health records be released.

The form may be used to obtain information from other providers and when used for that purpose, it should be completed with the same concern for the statutory, common law and constitutional requirements. Such attention to detail may ultimately save both time and effort.

The Medical Practices Act, the Communicable Disease Prevention and Control Act and certain other statutes, for instance, those relating for mental health and mental retardation information, provide several other exceptions to the rule of confidentiality relating to medical records.

ANY REQUEST FOR INFORMATION WHICH CANNOT BE ADDRESSED BY THE USE OF THE CONSENT TO RELEASE CONFIDENTIAL INFORMATION FORM MUST BE REFERRED IMMEDIATELY TO THE OFFICE OF GENERAL COUNSEL FOR NECESSARY ACTION. Because the Public Information Act and other statutes give a very limited time period during which the agency must respond to requests for information, any delay in making these referrals may lead to results which are adverse to the agency.

Please review the release form before releasing information. All blanks on the form must be filled in, the form must be read by the client, and the form must be appropriately signed before the information is released. The client must receive a signed copy of the authorization.