AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the Austin/Travis County Health & Human Services Department to (circle one) ***release/obtain*** medical information concerning:

Patient Name: _____ Date of Birth _____/_____/_____

Address: _____ City _____ State _____ ZIP _____

Soc. Sec. No _____/_____/_____ Telephone Number: _____ Dates of Service: _____

This information is to be *released to/obtained* from (circle one)

Facility / Person_____

Address_____

City/State_____ Zip_____

Telephone Number_____

Return Address

Facility___APH, Immunization Program_____

Address__15 Waller St._____

City/State__Austin, TX_____ Zip__78702_____

Telephone Number___512-972-5520_____

Please release the following information, indicated by an "X":

____Progress/Clinic Notes	____Consultation	____Hospital Summary Sheet	☐ HIV/STD Medical Information	_____
____ Lab Results/X-Rays	____ History & Physical	_____ Operative Report (s)		
____ Tuberculosis Elimination Records	____ Discharge Summary		☐ Psychiatric	_____
____ Social Work Notes	__X_ Other___Immunization Record_____		☐ Substance Abuse Records	_____

Initials

This information is necessary for the following purposes:

___Follow-up Care _X_Patient is requesting disclosure ___Disability Benefits ___Attorney**

___Other** Please Explain_____ ****Indicates Fee for Service**

Will Financial/compensation result in use or disclosure? ☐ Yes **X** No

Please release my information via: ___Mail ___Orally ___Pick-up ___ Fax (Emergencies Only) (Fax No._____)

I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall expire in six (6) months from when it is signed unless otherwise specified (Otherwise specified date_____). Upon expiration, the ATCHHSD can no longer use or disclose my information for the above purposes without a new authorization. All revocations will be sent to the attention of the Clinic Manager and become effective once received.

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipients(s) of that information.

I understand any of the above requested information may include results of sexually transmitted disease, acquired immunodeficiency syndrome(AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders.

I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. You may refuse to sign this authorization.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a coy of this form after I sign it

FOR OFFICE USE ONLY: ☐ Authorization added to the patient's medical record on _____.
☐ Authorization verified by _____ on _____.
☐ Patient has been provided with a copy of the signed authorization.

THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

_____

Signature of Patient or Authorized Party Date Relationship to Patient

Witness_____Reason for Patient Not Signing_____