AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

PATIENT'S NAME _____

I authorize _____ and/or _____, and/or
(Name of HMO) (Name of BHO)

the following person/agency/group:

_____
Provider/Agency/Group Address City State ZIP

To disclose information and records regarding my treatment, medical and/or behavioral health condition to the following professional person/agency, physician and/or facility;

_____
Provider/Agency/Group Address City State ZIP

Information to be released or exchanged include (check all that apply):

_____ History and physical

_____ Discharge and Summary

_____ Behavioral Health Treatment Records

_____ Laboratory Reports

_____ Physical Health Treatment Records

_____ Medication Records

_____ Information on HIV or communicable disease treatment

_____ Other (specify) _____

The authorized purpose(s) for this release are:

_____ Diagnosis and Treatment

_____ Coordination of Care

_____ Insurance Payment Purposes

_____ Other (specify) _____

I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or 60 days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me as I signed it of my own free will on:

The _____day of _____, 20____.

_____ _____

Signature of Client Signature of Witness

_____

Signature of Parent, Guardian, or Authorized Representative, if required

NOTICE OF CLIENT'S REFUSAL TO RELEASE INFORMATION:

I have reviewed the above release of information form and refuse to authorize release of health and behavioral health information to mental health and/or alcohol and/or drug abuse treatment providers and/or physical health providers.

Executed this _____day of _____, 20____.

_____ _____

Signature of Client Signature of Witness

_____

Signature of Parent, Guardian, or Authorized Representative, if required

The person signing this authorization is entitled to a copy.

TO PERSON RECEIVING THE CONFIDENTIAL INFORMATION: PROHIBITION OF REDISCLOSURE

Federal and state law protects the confidentiality of the information disclosed to you related to the individual's alcohol and drug abuse treatment. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Disclosure is limited to the purpose and persons included on the authorization form. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State laws may also protect the confidentiality of the client's records.

TO THE INDIVIDUAL FILLING THIS OUT:

You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method of asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact NorthSTAR. You can write to NorthSTAR at 1199 S. Beltline Rd., Coppell, Texas 75019. You can also call the NorthSTAR Helpline at 1-972-906-2500.