Account #:	



Authorization to Disclose Protected Health Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information (PHI). Covered entities as that term is defined by HIPAA and Texas Health & Safety Code §181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Individuals cannot be denied treatment based on a failure to sign this authorization form.

Signature of Minor Client

Client Name				
Other Name(s) Used				
DOB	SSN			
Address- Line 1				
Address- Line 2				
City		State	Zip	
Phone		Alt. Phone		
Email Address (Optional):				

performing certain insurance functions, or as may be otherwise authorized by law. Individuals cannot be denied treatment based on a failure to sign this authorization form.			Phone Alt. Phone Email Address (Optional):		
West Texas Counseling & Go 36 E. Twohig Ave, Cactus Ho Mailing- 242 N. Magdalen, S	itel, 6th Floor an Angelo, TX 76903	e the Individua	al's PHI: www.wtcg.us	REASON FOR DISCLOSURE (Choose only one option below) Treatment/Continuing Medical Car Personal Use Billing or Claims	
Who Can ☐ Disclose and/o Person/Organization Name_ Address	r ☐ Receive/Use the Individual Receive/Use the	dual's PHI? Zip Code		□ Insurance □ Legal Purposes □ Disability Determination □ School □ Employment □ Other	
minor client is required for t All health information Progress Summary Diagnosis Progress Notes Your initials are required to Mental Health Recor		items. If all here sults consults consults consults community comm	_		
EFFECTIVE TIME PERIOD. The reaching the age of majority; or RIGHT TO REVOKE: I understand authorization to the person control actions taken in reliance on SIGNATURE AUTHORIZATION that refusing to sign this form permitted by law without my Safety Code §181.154(c) and	is authorization is valid until r permission is withdrawn; or the stand that I can withdraw my peon or organization named under this authorization by entities to DN: I have read this form and m does not stop disclosure of the specific authorization or permission.	ne following spectarmission at any "WHO CAN RECT that had permised agree to the f health informatission, including understand that	ific date (optional): time by giving written no- CEIVE AND USE THE HEA ssion to access my heal uses and disclosures of ation that has occurred and disclosures to covered information disclosed p	eath of the individual; the individual tice stating my intent to revoke this ALTH INFORMATION." I understand that prior the information will not be affected. the information as described. I understand prior to revocation or that is otherwise and entities as provided by Texas Health & pursuant to this authorization may be vacy laws.	
A minor individual's signature i	ationship to the patient: ☐ F	Parent of mino	ormation, including for ex	Other cample, the release of information related to	
certain types of reproductive care. Fam. Code §32.003).	are, sexually transmitted diseas	es, and drug, alc	onoi or substance abuse,	and mental health treatment (See, e.g., Tex.	

Rev: May 2017 Page **1** of **2**

Date

Important Information About The Authorization To Disclose Protected Health Information

This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181).

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code §181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's PHI. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§181.154(b), (c), §241.153; 45 C.F.R. §§164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code §151.002(6); Tex. Health & Safety Code §\$166.164, 241.151; and Tex. Probate Code §3(aa)).

Health Information to be Released- If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR §164.501).
- Drug, alcohol, or substance abuse records.
- · Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. §164.502).

Note on Release of Health Records- This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§164.502(a)(1)(i), 164.524; Tex. Health & Safety Code §181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental, or emotional health. (Tex. Health & Safety Code §§181.102, 611.0045(b); Tex. Occ. Code §159.006(a); 45 C.F.R. §164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. §164.522(a)(1)(vi)).

Limitations of this form- This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. §164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. §164.508(b)(3)(ii); or for research purposes (45 C.F.R. §164.508(b)(3)(i)). Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

Charges - Some covered entities may charge a retrieval/ processing fee and for copies of medical records. (Tex. Health & Safety Code §241.154).

Right to Receive Copy- The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization

Rev: May 2017 Page **2** of **2**