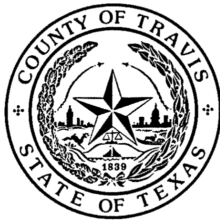

Authorization for Release of Protected Health Information

Description: This form allows Travis County to use and disclose certain protected health information as described below.

Part I: To whom does the authorization apply?

Name:____

Date of birth:_____________________________ Last 4 SSN:____

Address: ____

Street City State Zip Code

Telephone Number: (_____)___________________

Part II: To whom may we disclose the information and for what purpose?

I authorize Travis County __________________________________to use and disclose the health information described in Part III at:

Department or Program Name

Recipient Name:____

Address:____

Street City State Zip Code

Phone Number: (______) __ Fax Number: (______) _

For the purposes of:

☐ Ongoing Treatment/Care
☐ Personal use
☐ Invoicing or claims
☐ Sure
☐ Legal Issues
☐ Determination of disability
☐ School
☐ Employment
☐ Other ________________ _

Part III: What information can be disclosed? Mark only the items that you want to be disclosed. If all health information is to be published, check only the first box. Please note that your initials or the signature of a consenting minor may be necessary for the release of some of these items.

☐ All health information
☐ History/Physical Exam
☐ Drugs past/present
☐ Doctor's Orders
☐ Consultation reports
☐ Progress Notes
☐ Discharge Summary
☐ Billing Information
☐ Other______________________

Your initials are needed to release the following information:

________Mental health records (excluding psychotherapy notes)

________Drug, alcohol, or substance abuse treatment records

________Records containing genetic information

_______Records containing HIV/AIDS test results or treatments

The signature of a consenting minor is required to disclose the following information:

____ Records related to hospital, medical, or surgical treatment for pregnancy

____ Records related to the examination and treatment of drug or chemical addiction, dependence, or use

____ Counseling records related to the prevention of suicide, addiction or chemical dependence, or sexual, physical, or emotional abuse

_______________________________________ Records related to the diagnosis and treatment of notifiable infectious, contagious or communicable diseases

Part IV: When will this authorization expire?

This authorization is valid until: (i) the death of the person whose information is to be disclosed; (ii) the person reaches the age of majority; (iii) the authorization is withdrawn; or (iv) the next specific date , whichever comes first.

Part V: Important Information

- This authorization form does not prohibit Travis County from disclosing any protected health information as permitted by federal and state law.
- This authorization may be revoked at any time before its expiry date. To revoke this authorization, simply notify in writing to the address set forth in the Shipping Instructions below.
- Revocation of this authorization will not affect uses or disclosures that occurred prior to the date Travis County received the revocation and will not be effective in revoking authorizations obtained as a condition of obtaining insurance coverage if the insurer has the legal right to contest a claim.
- Once protected health information is disclosed to the recipients described in Part II, the information has the potential to be disclosed by these recipients and can no longer be protected by the HIPAA Privacy Rule. Travis County is not responsible for any further disclosure by recipients.
- I am not required to sign this Authorization to receive any health care treatment, to enroll in a health plan, or to be eligible for benefits.

_______________________________________ _______________________

Signature of the individual (or personal representative) *Date*

If you are a personal representative of the individual, provide your name, address, telephone number, relationship to the individual and proof* of your legal status as a personal representative:

Name: ____

Address: ____

Street City State Zip Code

Phone Number: (H)______________________ (W)______________________

Relationship with the individual:_______________________________

**Travis County will accept documentation such as an executed will, power of attorney, or court order as proof of your legal relationship. You must also provide a valid government-issued photo ID.*

Shipping Instructions

Complete this form and return it to:

HIPAA Compliance and Privacy Office
700 Lavaca, Ste. 400
Austin, TX 78701

You can also email a scanned form to: privacy@traviscountytx.gov

FOR OFFICE USE ONLY

Date of receipt:__________ Received by:_________________________ Title:____________________

Verification of the identity of the applicant:	If the application was submitted by a Personal Representative, the authority of the Personal Representative was verified by:
☐ Photo ID ☐ Identifying Information ☐ Matching signature ☐ Other: ____	☐ Executed will ☐ Power of Attorney Documentation ☐ Authorization signed by the individual ☐ Other: ____

Date on which PHI was disclosed/published:_________________

Note 1: A minor is a person under 18 years of age, who is not and has not been married, or who has not had the minority disabilities eliminated by the court. A minor may consent to receive medical, dental, psychological/psychological and surgical treatment on their behalf when:

- On active duty with the armed forces;
- At the age of 16 or older, the minor resides separately and separately from his or her parents and manages his or her financial affairs. ;
- Treatment is for an infectious, contagious, or transmissible disease that must be reported by law. ;
- The child is single and pregnant, and the treatment is related to pregnancy;
- Treatment is for addiction or dependence on drugs and chemicals; or
- Counseling is for sexual, physical or emotional abuse, suicide prevention, or addiction or chemical dependence.

Note 2: An authorization for the disclosure of psychotherapy notes must be completed on a separate form and cannot be combined with other authorizations for the disclosure of information.

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