Emergence Health Network
El Paso Center for Mental Health/Intellectual Disabilities

Client #: _____

Medicaid #: _____

Unit: _____

Authorization to Release Information

1. The patient whose information may be used, disclosed, or exchanged is:

Patient Name:		DOB:	

2. I authorize the designated staff at Emergence Health Network to ☐ Disclose or ☐ Receive my protected health information
3. Information to be disclosed to:

Name:		Address:			
City:		State:		Zip Code:	
Phone Number:		Fax Number:			

4. Information to be released/received/used:

☐ Progress Notes: (make a selection below)
- ☐ Medical Progress Notes
- ☐ Caseworker Progress Notes
- ☐ Therapy Progress Notes

☐ Psychiatric Evaluation
☐ Discharge Documentation
☐ Complete medical record

☐ Labs
☐ Billing Records

☐ Other (specify below)

Covering the period(s) of treatment:

From:		To:	

5. Send copies to:

Mail copies (complete address):	
Pick-Up copies (clinic location):	
Fax copies (attention to):	
Email copies:	

6. I authorize the disclosure of my health information regarding (a selection is required to consent or deny the release of the following information):
   - ☐ Yes ☐ No Alcohol or Substance Abuse Records
   - ☐ Yes ☐ No HIV/AIDS Records
   - ☐ Yes ☐ No Genetic Information (including Genetic Test Results)
7. Purpose of disclosure:

☐ at my request
☐ legal purposes
☐ billing and claims
☐ educational purposes
☐ treatment/continuity of care
☐ to verbally disclose the care and treatment I receive
☐ other:

8. The persons or organizations receiving any disclosure of this information may disclose again. It may not be possible to ensure your right to the protection of the privacy of this information once EHN discloses it to another party.

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Authorization to Release Information

This authorization will expire in (1) year from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by the following date:

Effective Date:		Expiration Date:	

I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

☐ I deny authorization (revoke)

I understand that EHN is sensitive about patient's trauma and realizes the effects it can have. EHN encourages clients to participate in treatment decision making by giving them a voice and choice about the information that is shared with EHN and its staff. EHN promotes a trauma informed approach to its care and interactions with patients to reduce re-traumatization.

If I choose not to give permission to share alcohol and/or substance abuse treatment information, EHN will still provide my information to my medical provider(s), however, every document in my medical record will have to be reviewed to ensure that the substance and/or substance abuse treatment information is not shared.

RIGHTS OF THE PATIENT:

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization

EFFECT OF REFUSING AUTHORIZATION: Patients cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(b),(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

I am the patient or personal representative of the patient whose records will be used, disclosed, or exchanged. I give permission to use, disclose, and exchange records as described in this document.

_____ _____

Signature of Patient or Patient's Legally Authorized Representative **Date**

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the patient: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ _____

Signature of a Minor Individual **Date**

Please allow 10 calendar days for your request