PSYCHIATRY OF TEXAS
GENERAL AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, consistent with State and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

I authorize: ___Psychiatry of Texas 13325 Hargrave Rd. Suite 240, Houston, TX 77070
Or _____
To release to: _____
(Name/Address)
The protected health information of: _____
(Name of Patient)

_____ _____ _____
(Address) (Date of Birth) (Phone)

_____
(City/State/Zip)

For the following purpose: __Physician/Health Care Provider __Legal __Personal __ Other

For: Inpatient treatment dates: _____Outpatient treatment dates: _____
Information to be disclosed:
__ Abstract chart (Final Discharge Summary, History& Physical, Consults, Diagnostic Results)
__ Entire Medical Record
__ History and Physical __Consultation __Operative Report __Discharge Summary
__ Pathology Report __Physician orders __Progress notes __Emergency record
__ Treatment plan __Radiology report __Psych Evaluation __Laboratory_____
__ Other Diagnostic reports: _____
__ Other: _____
*Health information may be viewed, in lieu of copies, by the requesting patient or legal representative, if done in the presence of a staff member, according to hospital policy.

I specifically request that the following information be disclosed and that it is protected by Federal or State law;
Check all that apply: __Drug & Alcohol Abuse, ___Mental Health, __ HIV/AIDS, __Child Abuse
According to State and Federal law, re-disclosure of health information involving patients treated for drug and alcohol abuse, mental health, HIV-AIDS, and child abuse is prohibited unless disclosure is expressly permitted by consent of the person to whom it pertains or as otherwise permitted by law.

I understand that if a person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations

I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect the use or disclosure of my health information for purposes of treatment, payment and health care operations.
I may inspect or copy any information disclosed under this authorization (unless made directly to me or in accordance with hospital policy requiring my attending physician's approval)

This consent may be revoked by me at any time, in writing, except if I am participating in alcohol/drug treatment under a court order or as an official condition of any criminal proceeding, or to the extent that action based on this consent has been taken prior to the receipt of request for revocation or until it expires under applicable laws. This authorization will expire 12 months from the date of my signature. I acknowledge that I have received a copy of this authorization. I also acknowledge that the organization may receive payment as a result of the disclosure of my health information.

_____ _____ _____
SIGNATURE of PATIENT DATE TIME

_____ _____ _____ _____
SIGNATURE OF LEGAL REPRESENTATIVE DATE TIME RELATIONSHIP TO PATIENT
*Must be stated by Legal Representative

Patient Label