



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: Whose information does the authorization apply to?

Name: _____

Date of Birth: _____ Last 4 Numbers of 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 to: _____
Name of the Department or Program

Recipient's Name: _____

Address: _____

Street City State Zip Code

Telephone Number: (____) _____ Fax Number: (____) _____

For the purpose of:

| | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Treatment/Continuing Medical Care | <input type="checkbox"/> Insurance | <input type="checkbox"/> School |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Legal Matters | <input type="checkbox"/> Employment |
| <input type="checkbox"/> Billing or Claims | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Other _____ |

Part III: What Information can be disclosed? Check only those items that you want to be disclosed. If all health information is to be released, then check only the first box. Please note that your initials or the signature of a consenting minor¹ may be required for the release of some of these items.

- | | | |
|---|---|--|
| <input type="checkbox"/> All health information | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Billing Information |
| <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other _____ |

Your initials are required to release the following information:

____ Mental Health Records (excluding psychotherapy notes²) ____ Records containing Genetic Information
____ Drug, Alcohol, or Substance Abuse Treatment Records ____ Records containing HIV/AIDS Test Results or Treatment

A consenting minor's signature is required to release 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, dependency or use
Counseling Records pertaining to suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse

Records pertaining to the diagnosis and treatment of reportable infectious, contagious, or communicable diseases

Part IV: When will this authorization expire?

This authorization is valid until the: (i) death of the individual whose information is to be disclosed; (ii) the individual reaches the age of the majority; (iii) authorization is withdrawn; or (iv) the following specific date _____, whichever is earliest.

Part V: Important Information

- This authorization Form does not prohibit Travis County from disclosing any protected health information as otherwise allowed by federal and state laws.
- This authorization may be revoked at any time before its expiration date. To revoke this authorization, simply give written notice to the address set forth in the Submission Instructions below.
- Revocation of this authorization will not affect uses or disclosures that occurred prior to the date that Travis County received the revocation and will not be effective to revoke authorizations obtained as a condition of obtaining insurance coverage if the insurer has a 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 further disclosed by these recipients and may no longer be protected by the HIPAA Privacy Rule. Travis County is not responsible for any subsequent disclosures by recipient(s).
- I am not required to sign this Authorization in order to receive any health care treatment, to enroll in a health plan, or to be eligible for benefits.

Signature of Individual (or Personal Representative)

Date

If you are a personal representative of the individual, please provide your name, address, phone 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 to 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 furnish a valid government issued picture ID.*

Submission Instructions

Complete this form and return it to:
Privacy Officer
700 Lavaca, Ste. 1500
Austin, TX 78701.

You may also email a scanned form to: privacy@traviscountytexas.gov

FOR OFFICE USE ONLY

| | |
|--|--|
| Date Received: _____ Received by: _____ Title: _____ | |
| Verification of Requestor's Identity: | |

| | |
|---|---|
| <input type="checkbox"/> Photo ID <input type="checkbox"/> Identifying Information <input type="checkbox"/> Matching Signature <input type="checkbox"/> Other: _____ | If the request was submitted by a Personal Representative, the authority of the Personal Representative was verified by: <input type="checkbox"/> Executed Will <input type="checkbox"/> Documentation of Power of Attorney <input type="checkbox"/> Signed Authorization by the Individual <input type="checkbox"/> Other: _____ |
| Date PHI was Disclosed/Released: _____ | |

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

- On active duty with the armed forces;
- At the age of 16 years or older, the minor resides separately and apart from their parents and manages their financial affairs;
- Treatment is for an infectious, contagious or communicable disease that is required to be reported by law;
- The minor is unmarried and pregnant and treatment is related to pregnancy;
- Treatment is for drug and chemical addiction or dependency; or
- Counseling is for sexual, physical or emotional abuse, suicide prevention or chemical addiction or dependency.

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