Release of Information
Request

Texas Health Care

Patient's Name_____ Maiden/Former Name:_____

Patient's Address:_____

City, State, Zip:_____

Birth Date:_____ Social Security #:_____

Home Phone:_____ Other Phone:_____

I, Authorize:	To Release to:
_____	_____
_____	_____
_____	_____

The following information may be released:	**Purpose of Disclosure:**
Entire Medical Record	Medical Care
Specific Record From_____to_____	Insurance
Immunizations	Attorney
Billing Record	Other_____
Only_____	

I consent to the release of the indicated sensitive, legally protected records (patient to initial).
Mental Health Records……_____
HIV or AIDS ……_____
Chemical Dependency……_____
Genetic Testing……_____

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically in 180 days from the date of authorization.

I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____
Signature of Patient or Representative: Date:

_____ _____
Printed Name: Relationship to Patient:

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42FR Part2) and cannot be disclosed without this written consent unless otherwise protected.