TEXAS
Department of Aging and Disability Services

Authorization for Disclosure, Use, or Receipt of Protected Health Information

(**Note: For individuals receiving alcohol or drug abuse treatment**, this form serves as the consent required by 42 CFR §2.31.)

You have the right to refuse to sign this authorization.
DADS will not withhold treatment, Medicaid benefits, or payment processing if you refuse to sign this authorization.

You will receive a copy of this signed authorization.

Individual	Case No.	DOB

I authorize the designated staff at: (name of facility)

to disclose/use/receive the following protected health information about me: (description of the specific types of information, including time period covered)

The facility's designated staff may disclose to/receive from: (name of person, organization, or facility)

The disclosure/use is for the following purpose(s):

- ☐ to coordinate my discharge planning/placement
- ☐ to assist in my educational placement
- ☐ at my request
- ☐ to assist in additional funding
- ☐ to discuss with my family the care and treatment I receive
- ☐ other: _____

I also authorize the disclosure/use/receipt of my health information regarding:

- ☐ HIV/AIDS
- ☐ alcohol and drug abuse treatment

Notes:

- If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.
- If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of an adult, the information disclosed/used/received may contain references about you and your family.

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the organization or facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

Unless this authorization is revoked earlier, it will expire on: (date, event, or condition of expiration)

_____ _____
Signature–Individual Date

_____ _____ _____
Signature–Representative, if any Representative's Relationship to Individual Date

A photocopy or facsimile transmission is as valid as the original.