AUTHORIZATION FOR DISCLOSURE, USE, OR RECEIPT OF PROTECTED HEALTH INFORMATION

YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION. NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY (NTBHA) WILL NOT WITHHOLD AUTHORIZATION, TREATMENT, BENEFITS, OR PAYMENT PROCESSING IF YOU REFUSE TO SIGN THE AUTHORIZATION.

CONSUMER INFORMATION

Name _____ Phone # _____

Date of Birth _____ Local Case # _____ Soc Sec # _____

Mailing Address (Street Address, City, State, Zip)

_____

AUTHORIZATION INFORMATION

I AUTHORIZE NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY, OR ITS DESIGNEE, TO DISCLOSE/USE/RECEIVE THE FOLLOWING PROTECTED HEALTH INFORMATION ABOUT ME (IN ANY FORM, INCLUDING VERBAL/WRITTEN/ELECTRONIC) FOR THE TIME PERIOD OF:

From Date _____ To Date _____

- ☐ Physician/Medication Orders
- ☐ Physician Progress Notes
- ☐ Psychiatric Evaluations
- ☐ Discharge Summaries
- ☐ Lab/X-Ray Reports
- ☐ Treatment Plans/Reviews
- ☐ Counseling Notes
- ☐ Nursing Notes
- ☐ Immunization Records
- ☐ ARDs/IEPs
- ☐ Academic Records/Transcripts
- ☐ Assessments

☐ HIV/AIDS Information (initials required) _____

☐ Alcohol/Drug Abuse Treatment Information (initials required) _____

☐ Other, specify: _____

Are you requesting that a copy of these documents be sent to the individual/organization shown below? ☐ Yes ☐ No

NTBHA's designated staff may disclose to/receive from the following individual, organization, or facility:

Name _____

Mailing Address (Street Address, City, State, Zip)

_____

Phone _____ Fax _____

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

- ☐ Coordinate discharge/referral/placement
- ☐ Assist with funding
- ☐ Research
- ☐ My request
- ☐ Court/Litigant/Attorney
- ☐ Assist in educational placement/planning
- ☐ Assist in employment/housing
- ☐ Give information about my treatment and services
- ☐ Child Protective Services (CPS)
- ☐ Other, specify: _____

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

NOTE: IF YOU ARE SIGNING AS A PARENT/GUARDIAN/MANAGING CONSERVATOR OF A MINOR OR AS A GUARDIAN OF THE PERSON 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 AGENCY 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 AGENCY, EXCEPT TO THE EXTENT THAT THE AGENCY 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 120 DAYS FROM THE DATE SIGNED BY THE CONSUMER OR LEGALLY AUTHORIZED INDIVIDUAL, OR AS OTHERWISE SPECIFIED BY DATE, EVENT, OR CONDITION OF EXPIRATION:_____.

Signature of Consumer _____ Date _____

Signature of Legally Authorized Individual _____ Relationship to Consumer _____ Date _____