Tarnow Center for Self-Management®

1001 West Loop S., #215 • Houston, Texas 77027 • 713-621-9515 • Fax 713-621-7015

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

NAME OF PATIENT

_____ DATE OF BIRTH _____/_____/_____

Last First Middle Month / Day /Year

ADDRESS _____ PHONE (_____)_____

CITY _____

STATE_____ ZIP_____

I AUTHORIZE: Tarnow Center for Self-Management 1001 West Loop South, #215 Houston, Texas 77027 To/From Person or Organization Name: _____ Address _____ City _____ State _____ Zip Code _____ Phone (_____)_____ Fax (_____)_____	☐ **To only RELEASE mental health/medical records TO** ☐ **To only RECEIVE medical/mental health records FROM** ☐ **To MUTUALLY SHARE records to/from** ☐ **To share information verbally** *If none of the above are checked, all apply*

WHAT INFORMATION CAN BE DISCLOSED? *Complete the following by indicating those items that you want disclosed. If all health information is to be released, then mark 'X' only on the first box.*

- ☐ All health information (marking this will include psychotherapy notes + cover all the items listed below)
- ☐ Psychiatric Information ONLY
- ☐ Treatment Plan/Testing Reports
- ☐ Other:_____

EFFECTIVE TIME PERIOD. This authorization shall become effective immediately and shall remain in effect for 5 years from the signature date unless alternate date listed here (optional): Month _____ Day _____ Year _____ or until revoked in writing.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Method of Delivery: ☐ -Mail ☐ -Fax(_____) ☐ -Pick Up ☐ -Email (_____)

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ___ Parent of minor ___ Guardian ___ Other _____

SIGNATURE X_____ _____

Signature of Individual or Individual's Legally Authorized Representative **DATE**