Tarnow Center for Self-Management
Authorization for Use and/or Disclosure of Patient Health Information

I Authorize: Tarnow Center for Self-Management
1001 West Loop South, #215
Houston, Texas 77027

[ ] To release and receive records to/from
[ ] To only release mental health/medical records to
[ ] To only receive medical/mental health records from
[ ] To share information verbally

If none of the above are checked, all apply

Name of Recipient

Address

City State Zip Phone

Records and Information Pertaining To: (*Please PRINT clearly)*

Patient's Name: Last First Middle

Home Address: Street City Zip

Patient's Date of Birth:

Duration: This authorization shall become effective immediately and shall remain in effect for 5 years from the signature date (unless alternate date listed here_____), or until revoked in writing.

Revocation: This authorization is also subject to written revocation by the patient at any time. This written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Check the box [X] to specify which type of information is to be disclosed; then sign and date your selection.

	Signature	Date
[ ] All Mental Health Records		
[ ] Psychiatric Information only		
[ ] Treatment Plan/Testing Report		
[ ] All of the above		
[ ] Other Health Information:		

The requested health information is authorized for the following purpose:

A copy of this authorization is as valid as the original/Patient has a right to a copy of this authorization.

Please indicate the means by which you want to obtain a copy of the requested information (fax, mail or pick up, etc.) and provide the necessary phone numbers or address(es) if different than shown above:

☐ Mail ☐ Fax _____ ☐ Pick up ☐ Other

Signature of patient 18 and older (or patient's representative) Date

Printed name of patient (or patient's representative) Relationship to patient