Texas Rehab of Fort Worth

Release of Information Authorization

I hereby authorize the use or disclosure of my protected health information (PHI) as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by Federal Privacy Regulations.

Patient Name (print): _____ Date of Birth: _____

Requesting Information FROM:	Providing Information TO:
_____	_____
_____	_____
Address	Address
_____	_____
_____	_____
City / State / Zip	City / State / Zip

Purpose of use or disclosure: _____

Specific description of information, including dates: _____

Method of Release: ☐ Fax #: _____ ☐ Mail ☐ Telephone ☐ Other

☐ E-record (information is not encrypted and may not be secure)

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____ (Date) or _____ (Event) Initials: _____

   (Expiration date not to exceed 12 months from date of signature below)

2. I understand that I may revoke this authorization as described in the Notice of Privacy Practices at any time by notifying the providing organization's Privacy Officer in writing, but if I do it won't have any affect on any actions they took in reliance on my authorization before they received the revocation. Initials: _____

3. I understand that my healthcare and the payment for my healthcare will not be affected if I do not sign this form. Initials: _____

4. I understand that I may see and copy the information described on this form if I ask for it, and that I get a COPY of this form after I sign it. Initials: _____

FURTHER, THE PHI AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, THE HUMAN IMMUNODEFICIENCY VIRUS (HIV), AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). I FURTHER UNDERSTAND THAT MY PHI MAY INDICATE THAT I HAVE BEEN TREATED FOR PSYCHOLOGICAL, PSYCHIATRIC OR SUBSTANCE ABUSE CONDITIONS.

_____ Date: _____

Signature (Patient or Patient Representative) Relation to Patient

Form MUST be completed BEFORE signing. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

PROVIDE COPY OF ROI TO PATIENT