Confidential Release of Information Form

Case #: __________

Address/Telephone: ☐ 1500 Pappas Street Laredo, TX 78041 956-794-3000
Fax all requests to: ☐ 101 US Hwy. 83 Zapata, Tx 78076 956-765-9664
956-794-3176 ☐ 106 E. Amada Street Hebbronville, TX 361-527-5771
☐ 2751 Pharmacy Road Rio Grande City, TX 78582 956-478-3748

I, ____________________________________, hereby authorize Border Region Behavioral Health Center to:
☐ release to ☐ obtain from ______________________________________ information from the record of:
Name: _____________________________________ Date of birth: ______________________________

Information may be released to and/or obtain from:
Name of Person/Agency/Entity: ____
Address: ____ City, State, Zip Code: _________________________
Phone Number: ___________________________ Fax Number: _____________________________
Email Address: ____

The information which may be released and/or obtained is limited to:
☐ Recovery Plan ☐ Diagnosis ☐ Mental Health Screening ☐ Physician's Progress Note
☐ Service Access-Intake Assessment ☐Psychiatric Evaluation ☐ Appointment Information
☐ Medications ☐ Lab Results ☐ Discharge Summary ☐ Treatment Plan
☐ Progress Notes ☐ Other: ____

This information is being released and /or obtained for the purpose(s) of:
☐ Treatment/Continuing Care ☐ Billing/Insurance Claims ☐ Educational Placement/Assistance
☐ Additional Funding ☐ Legal Proceedings ☐ Other: ________________________________

I understand that this authorization may include disclosure of information relating to mental health treatment, alcohol/substance abuse treatment, and confidential HIV/AIDS related information. In the event that the health information described above includes any of these types of information, I specifically authorize the release of such information as indicated below:

Mental Health Treatment: ☐ Alcohol/ Substance Abuse Treatment: ☐ HIV Related Information: ☐

Although I understand that I need not consent to the release of this information, I choose to do so willingly and voluntarily for the purpose(s) specified above. This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b), (c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508). The authorization provided by use of the form means that the organization, entity, or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501), Drug, alcohol, or substance abuse records and Records or tests relating to HIV/AIDS.

EFFECTIVE TIME PERIOD. This authorization is valid for one (1) year from year to date or until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _________ Day __________ Year _________

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 "INFORMATION CAN BE RELEASED TO." 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.

All items on this form have been completed and my questions about this form have been answered.

Individual signature: ____ Date: ___________________________________

☐ Signature of individual Age 17 or Older

☐ Signature of parent, other closest Relative or Guardian of individual under Age 17

Relationship to individual of parent, Closest Relative or Guardian: _______________________________________

Witness of signature (s): ____________________________________ Date: ___________________________________

I have been offered a copy of this form and I have ☐ Accepted ☐ Declined