



Austin/Travis County Health & Human Services Department

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the Austin/Travis County Health & Human Services Department to (circle one) release/obtain medical information concerning:

Patient Name: _____ **Date of Birth** ____/____/____

Address: _____ **City** _____ **State** _____ **ZIP** _____

Soc. Sec. No ____/____/____ **Telephone Number:** _____ **Dates of Service:** _____

This information is to be released to/obtained from (circle one)

Facility / Person _____

Address _____

City/State _____ **Zip** _____

Telephone Number _____

Return Address

Facility__ATCHHSD, Immunization Program_____

Address__15 Waller St._____

City/State__Austin, TX_____ Zip__78702_____

Telephone Number__512-972-5520_____

Please release the following information, indicated by an "X":

____Progress/Clinic Notes ____Consultation ____Hospital Summary Sheet

____Lab Results/X-Rays ____History & Physical ____Operative Report (s)

____Tuberculosis Elimination Records ____Discharge Summary

____Social Work Notes X Other____Immunization Record_____

☐ HIV/STD
Medical
Information

☐ Psychiatric

☐ Substance Abuse
Records

Initials

This information is necessary for the following purposes:

____Follow-up Care X Patient is requesting disclosure ____Disability Benefits ____Attorney**

____Other** Please Explain_____ ****Indicates Fee for Service**

Will Financial/compensation result in use or disclosure? ☐ Yes ☒ No

Please release my information via: ____Mail ____Orally ____Pick-up ____Fax (Emergencies Only) (Fax No._____)

I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall expire in six (6) months from when it is signed unless otherwise specified (Otherwise specified date_____). Upon expiration, the ATCHHSD can no longer use or disclose my information for the above purposes without a new authorization. All revocations will be sent to the attention of the Clinic Manager and become effective once received.

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipients(s) of that information.

I understand any of the above requested information may include results of sexually transmitted disease, acquired immunodeficiency syndrome(AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders.

I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. You may refuse to sign this authorization.

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

FOR OFFICE USE ONLY: ☐ Authorization added to the patient's medical record on _____.

☐ Authorization verified by _____ on _____.

☐ Patient has been provided with a copy of the signed authorization.

THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

Signature of Patient or Authorized Party

Date

Relationship to Patient

Witness_____ **Reason for Patient Not Signing**_____