AUTHORIZATION FOR RELEASE OF PATIENT SUBSTANCE USE DISORDER RECORDS

To (Circle One): Individual Recipient OR Third Party Payer Entity Recipient OR Treating Provider Entity Recipient

Patient Name ______________________________ Phone Number ______________________________

Other Names Used ______________________________ Date of Birth ________________ Social Security #: XXX - ________ - __________

I, the undersigned, authorize the release of the below specified health information by:

____

[Specific name(s) or general designation(s) of the Part 2 program(s), entity(ies), or individual(s) permitted to make the disclosures]

To: (Recipient of below health information):

____

[Name of Individual(s), Third Party Payer Entity OR Treating Provider Entity that will receive the information.]

______________________________ ______________ __________ __________

[Address] [City] [State] [Zip]

______________________________ ______________________________

[Telephone] [Fax]

Substance Use Disorder Information to be Released, Accessed, or Received: **(NOTE: patient must initial)**
Note: If any mental health or HIV/AIDS information is contained in my Substance Use Disorder information, I understand that this information will be included in the disclosure.

_____	History and Physical	_____	Clinical Summary	_____	Progress Notes-Therapist
_____	Psychiatric Assessment	_____	Diagnosis	_____	Treatment Plan
_____	Detox Records	_____	Medications	_____	Physician Orders
_____	Psychological Evaluation	_____	Emergency Assessment	_____	Complete SUD Record
_____	Consultation Report	_____	Lab Reports	_____	Intake/Admissions Report
_____	Psychosocial Report	_____	Nursing Assessment	_____	Family Collaboration Information (Verbal disclosure only)
_____	Discharge Summary	_____	Progress Notes-Physician		
_____	Face Sheet	_____	Progress Notes-Nursing		

OTHER____

The above information should be released from the time period beginning ________________ and ending ________________.

Patient Information is Needed for: **(NOTE: patient must initial)**

_____	Continuity of Medical Care	_____	Residential Treatment	_____	EAP
_____	Personal	_____	School	_____	FMLA
_____	Legal Purposes	_____	Social Security/Disability	_____	Family Collaboration Interactions (Verbal disclosure only)
_____	Payment	_____	Employer		

OTHER____

[Describe the purpose of the disclosure as specific as possible]

- For Substance Use Disorder records, a notice will accompany my records released pursuant to this authorization prohibiting the re-disclosure of the records according to the federal privacy law (45 CFR Parts 160 & 164) unless otherwise authorized or permitted by law.
- I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.
- I understand that I may revoke this authorization verbally or in writing at any time except to the extent that action has been taken in reliance upon the Authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing Law.
- This Authorization will expire One Hundred and Eighty (180) days from the date of my signature unless I revoke the Authorization prior to that time or unless otherwise specified by date, event or condition, as follows: ______________________________
- I have been provided a copy of this form.

Date: ____________________ Signature: ______________________________

Patient or Legally Authorized Representative

____

Printed Name of Patient or Legally Authorized Representative

____________________ ______________________________

For Department Use: MRN/Acct # Relationship to Patient

____

AUTHORIZATION FOR RELEASE OF PATIENT SUBSTANCE USE DISORDER RECORDS (Rev. 10/18) **PATIENT IDENTIFICATION**

Texas Health ____________________

(Entity Name)

9810