

# DENTON COUNTY MHMR CENTER

## AUTHORIZATION FOR THE DISCLOSURE OF INDIVIDUAL RECORD INFORMATION

**Texas Administrative Code - TITLE 22, PART 9, CHAPTER 165, RULE 165.2 (b): The requested copies of medical records and/or billing records shall be furnished by the physician/provider within 15 business days after the date of receipt of the request and reasonable fees for furnishing the information. A photocopy of this release is acceptable.**

\*You have the right to refuse to sign this authorization. DCMHMR will not withhold treatment, benefits, or payment processing if you refuse to sign this authorization, unless you are receiving treatment for alcohol or drug abuse and the purpose of the authorization is to obtain payment or provide benefits for your treatment.

Individual Name: \_\_\_\_\_ Case#: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize/request DENTON COUNTY MHMR CENTER to:

Release To:  Receive From:  Exchange With: The following Person, Organization, Provider or Agency below:

(Name, address, and telephone/fax number of Person, Organization, Provider or Agency)

**The information released may include:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Intake/Social History       | <input type="checkbox"/> Psychiatric/Psychological Evaluation | <input type="checkbox"/> Diagnosis                 |
| <input type="checkbox"/> Medical Progress Notes      | <input type="checkbox"/> Lab Results                          | <input type="checkbox"/> Eligibility Determination |
| <input type="checkbox"/> Treatment Plan/Service Plan | <input type="checkbox"/> Medical History/Treatment            | <input type="checkbox"/> Vocational Notes          |
| <input type="checkbox"/> Recommendations             | <input type="checkbox"/> Crisis Information                   | <input type="checkbox"/> Case Management Notes     |
| <input type="checkbox"/> Testing                     | <input type="checkbox"/> Discharge Summary                    | <input type="checkbox"/> Other _____               |

(Please describe specifically the type of information and time periods which apply.)

**If not revoked, this authorization will expire on \_\_\_\_\_; if not dated, expiration is one year from date signed below.**

I understand that such disclosure will be made for the following purpose(s):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Coordination/Continuity of Services | <input type="checkbox"/> To provide information to person(s) | <input type="checkbox"/> To assist in additional funding |
| <input type="checkbox"/> Treatment Planning /Evaluation      | <input type="checkbox"/> To assist in education placement    | <input type="checkbox"/> Insurance verification          |
| <input type="checkbox"/> Other: _____                        |  |  |

\*If I am signing as a parent of a minor child, or guardian of a minor child, I further understand that the record released may contain reference to my family or myself.

\*Unless specifically requested otherwise, I also authorize to the release of information regarding **HIV/AIDS, the presence of communicable or noncommunicable disease, and chemical dependency/substance abuse/use. This Authorization for Disclosure does comply with federal law 42CFR Part 2.** The individual who has signed below can withdraw this authorization at any time. A cancellation will prevent any further disclosures utilizing this authorization, other than disclosures made between the time of authorization and the time the authorization has been withdrawn.

\_\_\_\_ **Initial to EXCLUDE information regarding HIV/AIDS and chemical dependency/substance abuse.**

\*\*Except for information related to alcohol or drug abuse treatment, the information disclosed pursuant to this Authorization may not be protected by medical privacy laws and may be subjected to re-disclosure by the recipient.

\*You have the right to revoke this authorization. To revoke this authorization, you or your representative must deliver a written statement, signed by you or your representative, to a DCMHMR facility, providing the date and purpose of the authorization and your intent to revoke the authorization. Your revocation will be effective the date it is received by DCMHMR other than disclosures made between the time of authorization and the time the authorization has been withdrawn.

**THIS AUTHORIZATION WAS REVOKED \_\_\_\_/\_\_\_\_/\_\_\_\_. DRAW A SINGLE RED LINE THROUGH THIS PAGE.**

**Medical Records Fax: 940-565-0930**

Individual Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Representative Signature: \_\_\_\_\_, \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature and Relationship to the Individual) (Printed name)

Witness Signature: \_\_\_\_\_, \_\_\_\_\_ Date: \_\_\_\_\_  
(Printed name)

**\* You have the right to receive a copy of this signed authorization. \***