AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION UNDER A SUPPORTED DECISION-MAKING AGREEMENT

NAME OF ADULT WITH A DISABILITY

_____
Last First Middle

DATE OF BIRTH _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALTERNATE PHONE** (_____)_____

I ALLOW THE FOLLOWING PERSON, PROVIDER OR ORGANIZATION TO RELEASE MY INFORMATION, WHICH MAY INCLUDE PROTECTED HEALTH INFORMATION:

Name _____
Address _____
City _____ State _____ Zip _____
Phone (_____)_____ Fax (_____)_____

Name of Supporter Who Can Receive the Confidential Information?

Name _____
Address _____
City _____ State _____ Zip _____
Phone (_____)_____ Fax (_____)_____

REASON FOR RELEASE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Legal Purposes
- ☐ School
- ☐ Employment
- ☐ Other_____

WHAT INFORMATION CAN BE RELEASED? Complete the following by choosing those items that you want released. Check one of the following:

1. HEALTH/MENTAL HEALTH INFORMATION

☐ All health/mental health information:
☐ Only the following health/mental health information: _____

Your initials are required to release the following information:

____ Psychotherapy Notes
____ HIV/AIDS Test Results/Treatment
____ Drug, Alcohol, or Substance Abuse Records

2. CASE-RELATED INFORMATION

☐ My entire case file/records
☐ Only the following case-related information: _____

3. EDUCATION/SPECIAL EDUCATION INFORMATION

☐ All education/special education records
☐ Only the following education/special education records: _____

4. EMPLOYMENT INFORMATION

☐ All employment records
☐ Only the following employment information: _____

5. FINANCIAL/PROPERTY INFORMATION

☐ All financial/property records

☐ Only the following financial/property information: _____

_____

_____

6. HOUSING INFORMATION

☐ All housing records

☐ Only the following housing information: _____

_____

_____

7. SUPPORTS AND SERVICES

☐ All records related to any supports and services provided to me

☐ Only the following supports and services information: _____

_____

_____

PURPOSE OF AUTHORIZATION: I have entered a supported decision-making agreement with my supporter. I only authorize the release of my confidential information to my supporter so that my supporter can help me obtain a copy of the confidential information, help me understand the information contained in this confidential information and help me communicate my decisions based on this confidential information. My supporter shall ensure that my confidential information is kept privileged and confidential and is not subject to unauthorized access, use or disclosure. My supporter may only release my confidential information to any other person, provider or organization with my permission. I also retain the right to obtain my confidential information on my own without the help of my supporter.

EFFECTIVE TIME PERIOD. This authorization is valid until my death; the end of my supported decision-making agreement; my permission is withdrawn; or until (date): 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 release information to my supporter.

SIGNATURE AUTHORIZATION: I agree to the release of my confidential information to my supporter. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that I cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. I have read and agree with how my confidential information may be used and shared with my supporter.

SIGNATURE _____ _____

Signature of Adult with Disability **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Developed Pursuant Texas Health & Safety Code § 181.154(d)
Effective October 1, 2015

This authorization is based on a standard Authorization to Disclose Protected Health Information adopted by the Attorney General of Texas in accordance with Texas Health & Safety Code § 181.154(d). 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 must obtain a signed authorization form from the individual or the individual's legally authorized representative to electronically release that individual's protected health information.

The authorization provided by use of this form means that the organization, entity or person authorized can release, communicate, or send the named individual's protected health information to the organization, entity or person identified on this form, including through the use of any electronic means.

Definitions – In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 C.F.R. §164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health/Mental Health Information to be Released – If "All Health/Mental Health Information" is selected for release, health/mental health information includes, but is not limited to, all records and other information regarding health/mental health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health/mental health information. As indicated on this form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Psychotherapy notes.
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.

Note on Release of Health Records – This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a physician or mental health professional makes such a determination, DRTx will advise the individual about how the individual may seek access to these records under state or federal law.

Limitations of this form – This authorization form should only be used for the release of psychotherapy notes when the individual specifically requests the release of psychotherapy notes. **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 C.F.R. Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges – Some covered entities may charge a retrieval/processing fee and for copies of medical records
(Tex. Health & Safety Code § 241.154).

Right to Receive Copy – The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.