metrocare.

OFFICE USE ONLY: MRN_____

☐ Photo ID ☐ Signature Verified ☐ Other _____

Staff Name:_____

Staff Signature:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Disclosure: This authorization is intended to allow METROCARE to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. I reserve the right to remove this authorization at any time by providing written notice of removal to Metrocare for the named individual/facility. The removal will be effective as of the date it is received except to the extent Metrocare has already relied upon my authorization to use or disclose my health information as described in the Notice of Privacy Practices. Metrocare is prohibited from releasing psychotherapy notes without specific authorization for disclosure of psychotherapy notes. I understand the information released in response to this authorization may be re-disclosed to other parties.

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. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals 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.

SECTION I - CLIENT DATA

1. NAME: *(First, Middle, Last Name)*	2. DATE OF BIRTH: *(MM/DD/YY)*	3. SOCIAL SECURITY NUMBER:

4. PHONE NUMBER: *(999)999-9999*

SECTION II - DISCLOSURE

5. I hereby authorize Metrocare to disclose/use/receive the specified protected health information below from the medical record of the above-named individual. **The designated staff may ☐ disclose to *OR* ☐ receive from, the following organization or person:**

a. NAME OF FACILITY *OR* PERSON:	b. ADDRESS *OR* EMAIL:
c. PHONE NUMBER: *(999)999-9999*	d. FAX: *(999)999-9999*

6. TYPE OF INFORMATION:

☐ Mental Health Records ☐ Primary Care Records ☐ Cohen Records

☐ Intellectual & Developmental Disability Records

7. PERIOD OF TREATMENT: *(MM/DD/YY)*

FROM: TO:

8. PURPOSE OF DISCLOSURE:

☐ Personal Use ☐ Treatment/Continuing Care ☐ Attorney/Legal ☐ Educational Use

☐ Discuss with Family ☐ Disability ☐ Housing ☐ Other (*specify*):_____

9. INFORMATION TO BE RELEASED: ☐ ALL RECORDS (excluding psychotherapy notes) **OR select below:**

☐ Psychiatric Evaluation ☐ Medication List ☐ Treatment Plans ☐ HIV/AIDS Results

☐ Psychological Evaluation ☐ Diagnosis Letter ☐ Labs ☐ Sexual Transmitted Infection (STI) Results

☐ Provider Notes ☐ Progress Notes ☐ Other (*specify*):_____

10. ☐ I authorize the release of the selected information **including** all records that include any substance use disorder and/or substance use disorder treatment records, **or**

☐ I authorize the release of the selected information **excluding** all records that include any substance use disorder and/or substance use disorder treatment records.

SECTION III - EFFECTIVE TIME PERIOD

11. This authorization is valid until _____. If no date is specified, this authorization will expire one (1) year from the date the authorization is signed.

SECTION IV - SIGNATURES

12. INDIVIDUAL SERVED: (Print)	13. SIGNATURE: *DATE: (MM/DD/YY)*
14. LEGALLY AUTHORIZED REPRESENATIVE: (Print) RELATIONSHIP:	15. SIGNATURE: *DATE: (MM/DD/YY)*