



DIGNITY EXTENSIVISTS OF CENTRAL TEXAS

Authorization for Release of Protected Health Information (PHI)

Compliant with Texas Medical Records Privacy Act & HIPAA Rules

PATIENT INFORMATION

Patient Name _____ DOB _____

SSN (Last 4) _____ Phone _____ Email _____

Address _____

1 AUTHORIZATION & DIRECTION

I hereby authorize Dignity Extensivists of Central Texas to:

- ☐ **DISCLOSE / RELEASE** medical records **TO** the Recipient named below.
- ☐ **REQUEST / RECEIVE** medical records **FROM** the Facility/Provider named below.

2 RECIPIENT / SOURCE INFORMATION

Entity / Person Name _____

Address _____

Phone _____ Fax _____

3 SPECIFIC HEALTH INFORMATION TO BE DISCLOSED

Check all that apply.

- | | |
|--|--|
| ☐ Complete Medical Record / Chart | ☐ Laboratory & Diagnostic Reports |
| ☐ Physician Rounding & Progress Notes | ☐ Medication Administration Records |
| ☐ Discharge Summaries | ☐ Care Plans & Nursing Notes |
| ☐ Billing & Insurance Claims Records | ☐ Other: _____ |

Sensitive Information Explicit Consent: Texas law requires explicit authorization to release the following sensitive records. Please initial next to any category you specifically authorize for release.

_____ Mental Health / Psychotherapy Notes
_____ Substance Use Disorder Records
_____ HIV / AIDS / Sexually Transmitted Diseases Test Results & Care Records

4 PURPOSE OF DISCLOSURE

- | | |
|---|---|
| ☐ Continuity of Medical Care | ☐ Personal Request by Patient |
| ☐ Legal / Insurance Review | ☐ Facility Admission / Placement |
| ☐ Other: _____ | |

5 EXPIRATION & RIGHT TO REVOKE

- a. **Expiration:** This authorization expires on _____ [Date] or one (1) year from the signature date if no date is specified.
- b. **Right to Revoke:** I understand I may revoke this authorization at any time by submitting written notice to Dignity Extensivists of Central Texas at 5000 Plaza on the Lake, Austin, TX 78746. Revocation will not apply to records already disclosed in reliance on this authorization.

PATIENT / REPRESENTATIVE SIGNATURE

Signature _____ Date _____

Printed Name _____

If Signed by Legal Representative, State Relationship / Authority _____