Authorization for Release of Protected Health Information

I authorize the following: (Check one)

Correspondence between ☐

Release my medical records **TO** ☐ **FROM** ☐

Person/Entity/Relationship: **Samaritan Center**

Address: **8956 Research Blvd. Bldg. #2 Austin, TX 78758**

Telephone: **512-451-7337**

Fax: **512-451-8729**

(Check one) AND ☐ **TO** ☐ **FROM** ☐

Person/Entity/Relationship: ______________________________

Address: ______________________________

Telephone: ______________________________

Fax: ______________________________

For the course of treatment of:

Client Name: ______________________________

Date of Birth: ______________________________

Provider: ______________________________

Information disclosed is limited to:

☐ Entire Medical Record
☐ Psychosocial Assessment
☐ Progress Notes
☐ Billing Records
☐ Other (specify below):
____

This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is revoked in writing, and will expire one year from today's date – unless otherwise stated as follows, upon this expiration date or event: ______________________________.

I understand that I have the right to revoke this authorization at any time by sending written notification to the Samaritan Center. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. I have read and understand this form and agree to the uses and disclosures of the information as described. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I understand that I must specifically request in writing that records be requested in electronic format.

______________________________ ______________________________

Signature of individual or individual's legally authorized representative Date

A **minor's signature** is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g. Tex. Fam. Code 32.003).

______________________________ ______________________________

Signature of Minor Date