**NAME OF PATIENT OR INDIVIDUAL**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

**OTHER NAME(S) USED** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH** Month\_\_\_\_\_\_\_\_\_\_ Day\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CITY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STATE**\_\_\_\_\_\_\_ **ZIP**\_\_\_\_\_\_\_\_\_\_

**PHONE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ALT PHONE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL (Optional**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.** Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual’s legally authorized representative to electronically disclose that individual’s protected health information. 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.



**REASON FOR DISCLOSURE**

**(Choose only one option below)**

€ Treatment/Continuing Care

€ Personal Use

€ Billing or Claims

€ Insurance

€ Legal Purposes

€ Disability Determination

€ School

€ Employment

€ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL’S PROTECTED HEALTH INFORMATION:**  NEW HORIZON COUNSELING CENTER  5424 RUFE SNOW SUITE 304, NORTH RICHLAND HILLS, TEXAS 76180  P: 817-576-2447 F: 844-273-0993 |  |
| **WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?**  Person/Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **WHAT INFORMATION CAN BE DISCLOSED?** Complete the following by initialing by those items that you want disclosed. If all health information is to be released, then initial only the first box.  \_\_\_\_\_ All Mental Health Records \_\_\_\_\_ Progress Notes \_\_\_\_\_ Consultation Reports \_\_\_\_\_ Billing Information  \_\_\_\_\_ Intake Paperwork \_\_\_\_\_ Test Reports \_\_\_\_\_ Discharge Summary \_\_\_\_\_ Appt. Information  \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **HOW IS THIS INFORMATION TO BE DISCLOSED?** Complete the following by initialing by how you want the health information to be released. If any form of communication is preferred, then initial only the first box*.* **Email is not an option.**  \_\_\_\_\_Any Form \_\_\_\_\_ Mail \_\_\_\_\_Fax \_\_\_\_\_Phone \_\_\_\_\_Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **EFFECTIVE TIME PERIOD**: This authorization is valid until the earlier of the occurrence of death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):\_\_/\_\_/\_\_\_\_\_\_  **RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving the written notice stating my intent to revoke this authorization to the person or organization named under “WHO CAN RECEIVE AND USE THE HEALTH INFORMATION.” 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.  **SIGNATURE AUTHORIZATION**: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). 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.  SIGNATURE X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Individual or Individual’s Legally Authorized Representative DATE  Printed Name of Legally Authorized Representative (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If representative, specify relationship to the individual: \_\_\_\_\_ Parent of Minor \_\_\_\_\_ Guardian \_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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