AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

(In Conformance with HIPAA Federal "Privacy Rule" Regulations)

To: Physician, Provider or Facility Name; 45 CRF §164.508(c)(1)(ii): _____

Telephone:_____

Address: _____

_____

Name of person/entity to whom the records shall be released; 45 CRF §164.508(c)(1)(iii):

From: Family Court Services of Tarrant County
200 E Weatherford Street
2nd Floor, Family Law Center
Fort Worth, Texas 76196-0258

Caseworker's name: _____
Direct telephone no. _____
Facsimile no. 817-212-7063
Email: _____

Patient's name_____ Social Security No._____

Date of birth_____ Date(s) of service Birth-Present

I, the undersigned, authorize release of information specified below from the medical record(s) of the above-named patient.

The patient information is needed for legal purposes. 45 CRF §164.508(c)(1)(iv)

Description of records/information to be released (check all that apply); 45 CRF §164.508(c)(1)(i)**:**

☐ All in-patient dictation and diagnostic reports for date(s) of service
☐ Emergency room notes and diagnostic reports
☐ History and physical
☐ EKG
☐ Medication records
☐ Discharge summary
☐ Lab/pathology reports
☐ PFT
☐ Operative report
☐ Radiology
☐ Holter monitor
☐ Consultation notes and reports
☐ Echo
☐ Orders
☐ Face sheet
☐ Dental records, notes
☐ Progress notes
☐ Case notes
☐ Intake/history
☐ Diagnosis
☐ Results or summary of testing
☑ other (please specify) All Records including psychiatric/psychological/counseling

_____

_____

_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). 45 CRF §164.508(c)(2)(iii).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pr-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law. 45 CRF §164.508(c)(2)(i); 45 CRF §164.508(c)(2)(ii)**:**

This authorization will expire One Hundred Eighty (180) days from the date of my signature below, unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: _____. 45 CRF §164.508(c)(1)(v)

✓ Date of signature:_____

✓ Signature:_____
Patient or legally authorized representative; 45 CRF §164.508(c)(1)(vi)**:**

✓ Printed name: _____
Relationship to patient; 45 CRF §164.508(c)(1)(iv): Self/Parent

✓ Address:_____

✓ Telephone no._(_____)_____