tx lonestar solutions

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

The undersigned hereby authorizes the release of information from the health record of:

1. Client Name_____ Last 4 #s of SSN_____

   Date of Birth_____ Phone Number_____

2. **INFORMATION TO BE RELEASED FROM:** **INFORMATION TO BE RELEASED TO:**

   _____ Name _____

   _____ Address _____

   _____ _____

   _____ Phone _____

3. **INFORMATION AUTHORIZED FOR RELEASE (*CHECK ALL THAT APPLY*):**

   ___ Psychiatric Evaluation ___ Medications ___ Medical/Physical history
   ___ Discharge Summary ___ Labs ___ History/Psychosocial
   ___ Psychiatrist Notes ___ Nursing Notes ___ Therapy Notes
   ___ Other: _____

4. **RELEASE OF SPECIAL RECORDS**
   ***YOU MUST* CHECK ☑ *A RESPONSE TO* EACH of the following statements in the event your record may contain such information:**

   a. ___I DO ___I DO NOT authorize disclosure of records of alcohol or drug abuse treatment.
   b. ___I DO___I DO NOT authorize disclosure of records of treatment or diagnosis of HIV or AIDS (including test results).

   Alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accessibility Act, 45 CFR Parts 160 and 164. These rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

5. **PURPOSE FOR USE OR DISCLOSURE**: ☐Personal Use ☐Treatment ☐Legal ☐Other_____

6. **EXPIRATION**: Unless another date, event or condition is listed below, this authorization will expire one (1) year from the date it is signed. Other date, event, or condition: _____

7. I understand LoneStar Solutions may not condition treatment or eligibility for care on my providing this authorization except if such care is (1) research related, or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party. If Client refuses to provide authorization under the aforementioned circumstances, LoneStar Solutions may refuse to provide care or treatment for these purposes.

   I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164) and the Privacy Act of 1974 (5 USC 552a) and Client has the right to revoke this authorization at any time in writing and upon delivery to LoneStar Solutions except to the extent that action has been taken in reliance on this authorization, or if applicable, during an insurance contestability period. I may request a copy of this form.

_____ Date_____
Client Signature

_____ Date_____

Signature of: ☐Parent ☐Guardian ☐ if other, specify relationship: _____

Witness Signature:_____ Date_____
(required for release of hospital records

Form revised 06/22/2015