



# Authorization for Release of Protected Health Information (PHI)

I authorize the following protected mental health information to be released from the medical record of:

_____ LAST NAME (PLEASE PRINT)	_____ FIRST NAME (PLEASE PRINT)	_____ KNOWN BY
_____ EMAIL ADDRESS	_____ UTEID	_____ DATE OF BIRTH
		_____ TODAY'S DATE

**Verbal disclosure to a non-provider (e.g., family, friend, SES, faculty, staff):**

NAME/RELATIONSHIP \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

**To be released:**

Conversations as needed to facilitate continuity of care

Other \_\_\_\_\_

**Records release to Medical or Mental Health Provider:**

<b>Release PHI</b>	Counseling and Mental Health Center	<b>Release PHI</b>	NAME/ORGANIZATION/PROVIDER ROLE _____
<input type="checkbox"/> <b>From</b>	100 A West Dean Keeton, A3500	<input type="checkbox"/> <b>To</b>	_____
<input type="checkbox"/> <b>To</b>	Austin, TX 78712	<input type="checkbox"/> <b>From</b>	ADDRESS _____
	Phone 512-471-3515		CITY _____ STATE _____ ZIP CODE _____
	Fax 512-232-7314		PHONE _____ FAX _____

I understand that to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

<b>TO BE RELEASED</b>	<b>DATE OF SERVICE / PROVIDER</b>	<b>TO BE RELEASED</b>
<input type="checkbox"/> Counseling records _____		<input type="checkbox"/> Conversations as needed to facilitate continuity of care
<input type="checkbox"/> Psychiatric records _____		<input type="checkbox"/> Date of appointments
<input type="checkbox"/> Laboratory results _____		<input type="checkbox"/> Other, as specified below
<input type="checkbox"/> Treatment summary _____		
<input type="checkbox"/> Other: _____		

➔ **NOTE:** If specific dates to be released or a specific provider are not indicated, all records in the category marked will be released.

I understand that this authorization is valid for as long as I am a UT Austin student unless I notify CMHC otherwise. I may revoke this authorization in writing at any time except to the extent that CMHC has already relied on this authorization. I may revoke it by completing a CMHC Request to Amend Record Form and stating my intention to revoke this authorization. This form must be submitted to CMHC Records at the address/fax number above. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. If I do not want some of this information released, I must review this request with CMHC Administrative staff.

I understand my treatment will not be conditioned by my completion of this form. I will be billed per the posted fee schedule. The information will be provided to me within 15 days of my request.

➔ **NOTE:** If mailing or faxing this form, please include a copy of your photo ID.

_____ SIGNATURE OF CLIENT/PATIENT (OR IF LEGAL REPRESENTATIVE-STATE AUTHORITY TO ACT)	_____ DATE
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I have verified the client's/patient's identification and notified them of the fee, if applicable.

_____ CMHC STAFF/TRAINEE SIGNATURE	_____ DATE
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<b>CMHC STAFF ONLY</b>	Date Released: _____ Released by: _____
	Notes: _____