BEXAR COUNTY MENTAL HEALTH COURT INITIATIVE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Participant's Name: _____ SID: _____
LAST FIRST MIDDLE

Social Security Number: _____ Date of Birth: _____

Home Address: _____
STREET CITY STATE ZIP CODE

Home/Cell Phone: (____) _____ Alternate Telephone Number: (____) _____

I hereby authorize the **Bexar County Mental Health Court Initiative Staff to receive and/or disclose** my protected health information **from/to** the following entities (LINE THROUGH THOSE NOT APPROVED for receiving and/or disclosing information):

Bexar County Courts of Law
Bexar County Pre-Trial Services
Bexar County Criminal District Attorney's Office
Bexar County Detention Health Care Services
Bexar County District Courts
Bexar County Probate Courts
Laurel Ridge Treatment Center
SAPD Mental Health Detail Unit
San Antonio State Hospital
San Antonio Behavioral Health
Southwest General Hospital
University Health System _____
Methodist Healthcare _____
Baptist Health System _____
_____
Bexar County Public Defender's Office

Bexar County Community Supervision & Corrections Adult Probation Dept.
Center for Health Care Services
Crystal Counseling
Integrated Treatment Program
Haven For Hope
Reentry Program
Texas Department of Family and Protective Services
Volunteers on America
Lifetime Recovery
Alpha Home
Family Members/Significant Others:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Psychiatrist/Clinic _____
Primary Care Doctor/Clinic_____
Attorney _____

Description of item(s) to be released: (Check all that apply)

_____ Entire Health Care Record
_____ Mental Health Diagnosis/Treatment/Prognosis
_____ Alcohol/Drug Abuse History/Treatment/Prognosis
_____ Emergency Center/University Hospital Treatment
_____ Discharge Summary
_____ Nursing Notes
_____ Physician Progress Notes
_____ HIV-Related Information
_____ History and Physical
_____ Laboratory Results
_____ Case Management Notes
_____ Income/Benefits
_____ Employment/Unemployment Hx
_____ School Records/ARDs/Testing
_____ Offense History

I understand the information will be used or disclosed for the following purpose(s):

_____ Coordination of Care _____ Assistance and Support of treatment _____ Coordination of Social Services
_____ Other, specify _____

I understand the following which has been explained to me (see CFR §164.508 (c)(2)(i-iii):

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. To revoke this authorization, you must deliver a written statement signed by you or your legally authorized representative to a Mental Health Court Initiative Staff.
- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose(s) listed. I understand that this authorization is voluntary and treatment, Medicaid benefits, or payment processing will not be withheld if I refuse to sign this authorization.
- **Many of the organizations that I may have authorized to receive my health information are NOT health-care providers.**
- **If an organization authorized to receive my information is not a health-care provider, the released information is no longer protected by federal privacy regulations (45 CFR Parts 160 through 164), and that it may be re-disclosed by the recipient.**
- **The Mental Health Court Initiative cannot limit or control the subsequent use, reproduction, or dissemination of the health information I have authorized to be released. _____ (initial)**
- The requested information in my health records may include information relating to AIDS, HIV, psychiatric, behavioral or mental health services, and substance or alcohol dependency.
- **This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. _____(initial)**
- This authorization will be valid until _____ (Date) or until I am no longer a participant in the Mental Health Court Initiative.

_____ _____ _____ _____
Participant's Signature Date Staff Signature Date

If not the participant, person signing on participant's behalf:_____ Authority to sign:_____
Signature Date

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

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