

COLLIN COUNTY HEALTH CARE SERVICES

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby request and authorize Collin County Health Care Services to release and disclose the protected health information listed below to the following entity:

Name: _____
(Physician, Hospital, Clinic, Health Department, and/or Region)

Address: _____

Phone#: _____ Fax#: _____

Purpose of Disclosure: _____

Patient Information:

Name: _____ DOB: ___/___/___ SSN: _____

Address: _____

This request and authorization extends to only documents containing the following information:

- _____ All information pertaining to Patient
- _____ All medical information pertaining to Patient
- _____ All non-medical information pertaining to Patient
- _____ Only Statements of charges or payments
- _____ Only information pertaining to the following condition, injury or treatment: _____
- _____ Other (specify) _____

This authorization is freely given with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law.
2. A photocopy or facsimile of this authorization is as valid as the original.
3. I may revoke this authorization at any time. However, the revocation shall not apply to information previously released in reliance on this authorization.
4. Collin County and its officers and employees are hereby released from any legal responsibility and liability for disclosure of the information as noted above if disclosure is in accordance with this authorization.
5. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.

Patient Name (PRINTED)

Date

Patient's / Guardian's Signature

Legal Relationship to Patient (Same Parent, Guardian, etc.)

Social Security Number of Signer

(IHCP Coincides with Patient's Eligibility)

Revocation Date (if other than 60 days)

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Effective April 14, 2003