#  HUDSPETH REGIONAL CENTER

 **Authorization/Consent to Release or Obtain Protected Health Information**

Client/Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race:\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Personal Representative (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as the personal representative,

hereby authorize **Hudspeth Regional Center, P.O. Box 127-B, Whitfield, MS 39193**

to release or obtain (circle) my protected health information/records to/from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I specifically authorize/consent to the release or obtaining (circle) of health information/records pertaining to the following:

**Please indicate by initialing and/or describing the amount and type of health information** to be obtained/released):

\_\_\_\_\_\_\_\_Medication Records

\_\_\_X\_\_\_\_Medical History and Physical Examination(s)

\_\_\_\_\_\_\_\_Physicians Orders/Notes

\_\_\_\_\_\_\_\_X-ray and/or Lab Records

\_\_\_X\_\_\_\_Evaluations for (list area(s): psychology, medical/nursing, education, etc.)

\_\_\_X\_\_\_\_ \_\_\_\_\_\_ psychology, medical/nursing, education, etc.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Treatment Plans and Related Revisions, Progress Notes and Summaries for (list area(s):

 psychology, medical/nursing, education, etc.)

\_\_\_\_\_\_\_\_ Entire Health Information Record

\_\_\_\_\_\_\_\_Other (Describe other information/records to be disclosed/obtained)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**for the specific purpose** **of: Diagnostic Information**

 (Describe purpose or nature of the information to be disclosed/obtained.)

**Dates of service for which the information/record is requested or will be released:**

From: **Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  To: **Present\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that this authorization/consent will be **effective on** \_\_\_\_\_ date of signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and (effective mo/day/year)

**will expire on**\_\_\_\_\_\_\_\_\_one year from date of signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Indicate mo/day/year, event, or condition, not to exceed one year)

and cannot be renewed without my written authorization/consent.

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must provide a specific request to revoke the authorization in writing to (department) \_\_\_\_\_\_\_\_\_\_\_\_\_\_**D&E**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of (agency) \_\_\_\_\_\_\_\_\_\_\_**Hudspeth Regional Center**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my revocation will not apply to action or any information that has already been released/obtained in response to this authorization.

I understand that my authorizing the disclosure/obtaining of this health information is voluntary. I understand that I need not sign this form in order to receive treatment. I understand that I may inspect or copy information to be used or disclosed as provided for by law. I understand that any disclosure of information carries with it the potential for a redisclosure and that the information may no longer be protected by federal confidentiality laws***.*** If I have questions about disclosure of my health information, I can refer to the center’s Notice of Privacy Practices for Protected Health Information or contact Tina Hester, privacy offcer at Hudspeth Regional Center.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Client/Patient, if applicable) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Parent/Guardian/Judicially Authorized Representative, if applicable) (Date)

(Attach or include description of such representatives authority to act for the client/patient, if applicable.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Witness, if applicable) (Date)

**Note to Person(s) Receiving Information addressed in this authorization:**

This information has been disclosed to you from records, the confidentiality of which is protected by state and/or federal law(s) or regulations. These laws/regulations prohibit you from making further disclosure of this information without the specific written authorization/consent of the person to whom it pertains or of other persons as permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

(Center staff must provide a copy of the signed authorization to the client/patient and/or judicially authorized representative.)