TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

COMMISSIONER
Thomas Chapmond

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

To: _____
(Name of Health care provider or other entity maintaining health-related information)

From: _____ _____ _____
(Name and address of the individual) (date of birth) (SSN – not required)

Time Period Covered by this Authorization: This authorization covers information relating to all time periods unless a specific time period is listed here:_____

Expiration Date of Authorization: Until completion of the activity described below in the purpose section of this authorization, or 1 year from the date executed, whichever occurs sooner.

Person or Entity to Whom Records May be Released: any properly identified TDFPS employee.

Description of Records Authorized to be Released: _____
_____
_____

Purpose(s) of Authorization[1] (check all that apply):

- ☐ To conduct an investigation of alleged abuse or neglect:
- ☐ To provide protective or other services that require TDFPS employees to communicate with my healthcare providers;
- ☐ To conduct a background investigation;
- ☐ To provide access to my psychiatric or psychological records, other than psychotherapy notes;
- ☐ To obtain psychotherapy notes. (This option may not be selected with any other options. If selected, it must be the only selection on this authorization or appear on a separate one); and
- ☐ To communicate with my pharmacist or doctor concerning my prescription medications.

HIPAA Notices:

- You have the right to refuse to sign this authorization. TDFPS will not withhold any benefit if you refuse to sign this authorization. You will receive a copy of this signed authorization.
- If you authorize disclosure of information the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it may no longer be protected by medical privacy laws.

[1] For investigation or provision of services, TDFPS in certain cases is entitled to receive protected health information and the provider or entity is required to disclose such information without an authorization.

- If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family.
- You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the organization or facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to use or disclose your health information.

By my signature below, I hereby authorize the disclosure as set forth above, of my protected health information records, and release the holders of such information from all legal liability for the disclosure of such information, in accordance with the provisions of this authorization. A copy or facsimile of this authorization is valid as an original.

_____ Date:_____
Individual's signature

_____ _____ Date:_____
Representative's signature (if applicable) Relationship to individual