Lakeview TMS Center

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION Developed for Texas Health & Safety Code § 181.154(d) effective June 2013 Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that indi-vidual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT: _____

(Last, First, Middle)

DATE OF BIRTH: Month _____ Day _____ Year _____

FULL RESIDENTIAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

EMAIL ADDRESS: _____

REASON FOR DISCLOSURE: (Choose only one option below)

☐ Personal Use ☐ Treatment / Continuing Care

☐ Billing or Claims ☐ Insurance

☐ Legal Information ☐ Employment

☐ Other (specify) _____ ☐ Disability Information

I AUTHORIZE THE FOLLOWING TO USE, DISCLOSE, AND RECEIVE

THE ABOVE STATED INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person or Organization Name: _____

Address * _____

Phone Number * _____

Fax Number * _____

WHO CAN USE, DISCLOSE, AND RECEIVE THE HEALTH INFORMATION?

Lakeview TMS Center PLLC

2249 Ridge Road Rockwall TX 75087

Phone: 469-402-7867

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of the patient is required for the release of some of these items. If all health information is to be released, then please initial the box below.

_____ All health information including mental health (excluding psychotherapy notes); including Drug, Alcohol and Substance Abuse records,

Genetic information (including pharmacogenetic testing results)

_____ Other (Please specify): _____

EFFECTIVE TIME PERIOD : This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn in writing.

RIGHT TO REVOKE : I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under 'WHO CAN RECEIVE AND USE THE HEALTH INFORMATION. "I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I certify that I have read this form and understand and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prio r to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization

may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

Signature: _____ Date (MM/DD/YYYY): _____

Full Name of person signing form: * _____