DENTON COUNTY MHMR CENTER

AUTHORIZATION FOR THE DISCLOSURE OF INDIVIDUAL RECORD INFORMATION

Texas Administrative Code - TITLE 22, PART 9, CHAPTER 165, RULE 165.2 (b): The requested copies of medical records and/or billing records shall be furnished by the physician/provider within 15 business days after the date of receipt of the request and reasonable fees for furnishing the information. A photocopy of this release is acceptable.

You have the right to refuse to sign this authorization.

DCMHMR will not withhold treatment, benefits, or payment processing if you refuse to sign this authorization.

Individual Name: _____ Case#: _____ DOB: _____

I hereby authorize/request **DENTON COUNTY MHMR CENTER** to:

□ Release To: □ Receive From: □ Exchange □ Text/Email With: Person, Organization, Provider or Agency below:

_____

LIST ONLY ONE:(Name, address, and telephone/fax number of Person, Organization, Provider or Agency)above.

The information released may include:

□ Intake/Social History	□ Psychiatric/Psychological Evaluation	□ Diagnosis
□ Medical Progress Notes	□ Lab Results	□ Eligibility Determination
□ Treatment Plan/Service Plan	□ Medical History/Treatment	□ Vocational Notes
□ Recommendations	□ Crisis Information	□ Case Management Notes
□ Testing	□ Discharge Summary	□ Other_____

_____

(Please describe specifically the type of information and time periods which apply.)

If not revoked, this authorization will expire on _____; if not dated, expiration is one year from date signed below.

I understand that such disclosure will be made for the following purpose(s):

□ Coordination/Continuity of Services	□ To provide information to person(s)	□ To assist in additional funding
□ Treatment Planning /Evaluation	□ To assist in education placement	□ Insurance verification

□ Other: _____.

*If I am signing as a parent of a minor child, or guardian of a minor child, I further understand that the record released may contain reference to my family or myself.

*Unless specifically requested otherwise, I also authorize the release of information regarding **Mental Health**, **HIV/AIDS, the presence of communicable/noncommunicable disease, and chemical dependency/substance abuse/use.** **This Authorization for Disclosure does comply with federal law 42 CFR Part 2.** The individual who has signed below can withdraw this authorization at any time. A cancellation will prevent any further disclosures utilizing this authorization, other than disclosures made between the time of authorization and the time the authorization has been withdrawn.

___ Initial to EXCLUDE information regarding HIV/AIDS.

___ Initial to EXCLUDE information regarding chemical dependency/substance abuse.

(Staff searches by reading each document to redact to the best of our ability.)

**Except for information related to alcohol or drug abuse treatment, the information disclosed/emailed pursuant to this authorization may not be protected by medical privacy laws and may be subjected to re-disclosure by the recipient.

*You have the right to revoke this authorization. To revoke this authorization, you or your representative must deliver a written statement, signed by you or your representative, to a DCMHMR facility, providing the date and purpose of the authorization and your intent to revoke the authorization. Your revocation will be effective the date it is received by DCMHMR other than disclosures made between the time of authorization and the time the authorization has been withdrawn.

THIS AUTHORIZATION WAS REVOKED _____/_____/_____. DRAW A SINGLE RED LINE THROUGH THIS PAGE.

Medical Records Phone: 940-565-5267 Medical Records Fax: 940-565-0930

Individual Signature: _____ Date: _____

Representative Signature: _____, _____ Date: _____

(Signature and Relationship to the Individual) (Printed name)

Witness Signature: _____, _____ Date: _____

(Printed name)

*** You have the right to receive a copy of this signed authorization. ***

LG-16 Est.: 5/97 RV: 03/2023

File under Consents