The Rape Crisis Center
HELP. HOPE. HEALING.

Authorization to disclose Protected Information

Please read this entire form before signing and complete all of 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 or by fax disclose that individual's protected health information. The Rape Crisis Center will not deny services based on a refusal to sign this form. You will receive a copy of this signed authorization.

Client Name

_____

OTHER NAME(S) USED _____

DATE OF BIRTH _____

ADDRESS _____

CITY _____STATE_____ ZIP_____

PHONE (_____) _____

EMAIL ADDRESS (Optional): _____

I, _____, authorize designated staff at **The Rape Crisis Center** to disclose to and/or obtain the following information from: _____
Address _____City_____ State_____
Zip_____ phone (_____) _____ Fax (_____) _____

What information can be disclosed? **(Client should mark items to be disclosed)**

- ☐ **Progress notes/Case Notes**
- ☐ **Progress in Treatment/Professional Communication**
- ☐ Treatment Plan/Continuing care plan
- ☐ Medication Management Information
- ☐ Presence/Participation in Treatment
- ☐ Discharge/Transfer Summary
- ☐ **Mental Health Records (excluding psychotherapy notes)**
- ☐ Drug, Alcohol, or substance abuse records
- □ Other_____

Purpose for disclosure: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is otherwise, please specify: ☐ Personal Use ☐ Billing Claims ☐ Legal ☐ Disability ☐ School ☐ Employment ☐ Other: _____

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 18; the withdrawal of permission; or the following specific date (optional): _____

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 above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my information will not be affected.

Signature Authorization: I have read this form 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 information that has occurred prior 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 X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable):_____
If representative, specify relationship to the individual: ☐Parent of minor ☐ Guardian ☐ Other _____

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

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