Authorization to Release Confidential Information

Name: ____

(Name of Client) **(Date Of Birth)**

Address: ____

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

I authorize the following health care provider, attorney, counselor, school, etc.:

Brazos County Health Department

(Individual, Physician, Hospital, Clinic, Attorney, Counselor, School, etc.)

201 North Texas Ave, Bryan Texas 77803-5317

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

to release the following specific confidential information:

Yes ( ) No ( ) Developmental Information. Indicate specific information:

Yes ( ) No ( ) Educational Plan. Indicate specific information:

Yes ( ) No ( ) Financial Information. Indicate specific information:

Yes ( ) No ( ) Legal Information. Indicate specific information:

Yes ( ) No ( ) Medical Information. Indicate specific information:

Yes ( ) No ( ) HIV-Related Information. Indicate specific information:

Yes ( ) No ( ) Psychological Reports. Indicate specific information:

Yes ( ) No ( ) Social History. Indicate specific information:

Yes ( ) No ( ) Other. Indicate specific information:

to the following individual:

(Name or Position of Individual / Organization, if any represented)

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

The information released may be used by the individual, or the organization represented by the individual for the following purpose(s):

I understand that: 1) I may revoke this authorization in writing by contacting the DSHS office or program that obtained the authorization; 2) this authorization will not affect treatment, payment, enrollment, or eligibility for benefits; and 3) information disclosed as a result of this authorization could be subject to re-disclosure as authorized by law.

EXPIRATION DATE: This authorization will expire on [date or event] ______________________________
(If no date or event is stated, expiration is one year from the signature date.)

This form (___) was read by me (___) was read to me and I understand its meaning. All the blanks were filled in before the form was signed by me.

Signature

(Print / Type Name of Person Authorized to Consent to Release of Information)

(Signature of Authorized Person)

(Address) (Telephone) (Date)

PRIVACY NOTIFICATION
With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)