

# Garland Behavioral Hospital

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(please print)

<b>I authorize</b>		<b>Garland Behavioral Hospital</b>	
		<b>2300 Marie Curie Blvd 5<sup>th</sup> Floor</b>	
		<b>Garland, TX 75042</b>	
<b>To</b>	<input type="checkbox"/> <b>obtain information from</b>	<input type="checkbox"/> <b>release information to</b>	
_____			
Name of Person or Entity			
_____			
Address			
_____			
City			
Phone #		Fax #	

My initials below signify that I consent for the following type(s) of information to be released to the above individual/entity.

\_\_\_ Drug/Alcohol Abuse                      \_\_\_ Psychiatric conditions  
\_\_\_ HIV or AIDs related information      \_\_\_ Medical conditions

Do **not** release the following: \_\_\_\_\_

Treatment Dates: \_\_\_\_\_

### Information that may be released:

Medication Record                       Physician's Psychiatric Evaluation                       Physician's Progress Notes  
 History and Physical Exam Report                       Lab Results                       Nursing Progress Notes  
 Discharge Plan/Continuing Care Plan                       Discharge Summary                       Psychotherapy Progress Notes

Other assessments:  Nursing  Psychosocial  Intake  Substance Abuse  Other (specify) \_\_\_\_\_

### PURPOSE FOR WHICH INFORMATION IS TO BE USED:

\_\_\_ Continuing Care                      \_\_\_ School                      \_\_\_ Disability benefits  
\_\_\_ Legal                      \_\_\_ Personal                      \_\_\_ Employment conditions

If for legal purposes, give specific reason: (must be completed) \_\_\_\_\_

### AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Revocation must be in writing. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original.

### OTHER CONDITIONS:

**This information has been disclosed to you from records whose confidentiality may be protected by Federal Law:**

"Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." [RM 203, 7.2] Rev. 4-12-04

This consent expires one year from the date below unless otherwise specified: (cannot exceed one year) \_\_\_\_\_

Signature of Patient                      Date                      Signature of Parent/Guardian, if applicable                      Date

Witness, if applicable                      Date

Revocation: I hereby revoke the above authorization: Signature \_\_\_\_\_ Date \_\_\_\_\_