

**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"/> obtain information from <input type="checkbox"/> release information to <input type="checkbox"/> verbally provide a status update
	_____ Name of Person or Entity                      Relationship
	_____ Address
	_____ City    Fax #
Phone #	

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:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Medication Record                   | <input type="checkbox"/> Physician's Psychiatric Evaluation | <input type="checkbox"/> Physician's Progress Notes |
| <input type="checkbox"/> History and Physical Exam Report    | <input type="checkbox"/> Lab Results                        | <input type="checkbox"/> Nursing Progress Notes     |
| <input type="checkbox"/> Discharge Plan/Continuing Care Plan | <input type="checkbox"/> Discharge Summary/Order            | <input type="checkbox"/> Physician Orders           |
| <input type="checkbox"/> Treatment Plan                      | <input type="checkbox"/> Discharge Instructions             | <input type="checkbox"/> Financial                  |

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: \_\_\_\_\_

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

\_\_\_\_\_  
Witness, if applicable                      Date

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