Authorization for Disclosure, Use, or Receipt of Protected Health Information

(Note: For individuals receiving alcohol or drug abuse treatment, this form serves as the consent required by 42 CFR §2.31).

You have the right to refuse to sign this authorization. No medical professional at this facility will withhold treatment, Medicaid benefits, or payment processing if you refuse to sign this authorization. You will receive a copy of this signed authorization.

Patient: _____ **D.O.B.** _____**(MM/DD/YYYY)**

I authorize the designated staff at **FORT BEND COUNTY EMERGENCY MEDICAL SERVICE**
To disclose/use/receive the following protected health information about me*: (description of the specific types of information, including time period covered) -*

_____

_____

The facility's designated staff may disclose to/receive from: _____

(name of person, organization, or facility)

The disclosure/use is for the following purpose(s): Please the appropriate box(es)

- ☐ To coordinate my discharge planning/placement
- ☐ At my request
- ☐ To assist in my educational placement
- ☐ To assist in additional funding
- ☐ To discuss with my family the care and treatment I receive
- ☐ Other

I also authorize the disclosure/use/receipt of my health information regarding:

- ☐ HIV/AIDS
- ☐ Alcohol and drug abuse treatment

Note: If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in the authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.

Note: If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family.

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the organization or facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to us or disclose your health information as described in the Notice of Privacy Practices.

Unless this authorization is revoked earlier it will expire on:
(date, event, or condition of expiration)

_____ _____
Date *Individual's signature*

_____ _____ _____
Representative's signature, if any *Representative's relationship to individual* *Date*

Internal Use Only
NOTES:

ID of person in receipt of records verified by: _____