TEXAS DEPARTMENT OF CRIMINAL JUSTICE
HEALTH SERVICES DIVISION
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name (print): _____ TDCJ-CID#: _____
Social Security Number: _____ Date of Birth: _____

By signing this Authorization Form, I understand that I am giving my authorization to TDCJ's designated medical records custodians to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the following person(s) or organization(s):

Name of person(s) or organization(s): _____
_____
Street address: _____
City, State, and zip code: _____
Telephone number: _____
Facsimile number: _____

I specifically authorize the use and disclosure of the following PHI:
(Please provide a detailed description of the particular information you are authorizing to be disclosed)

ANY AND ALL INFORMATION FROM THE OFFENDER HEALTH RECORD (ALL FORMATS).

If this authorization is for any purpose other than the release of medical records for personal reasons, please state the purpose of the authorization to release PHI below:

RESPONDING TO AN INQUIRY REGARDING THE OFFENDER'S HEALTH AND/OR ACCESS TO HEALTH CARE..

The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care.

Unless earlier revoked, this authorization will expire on the 180th day of the signing or as otherwise specified below:

_____

I understand the information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or Texas privacy law.

I may inspect and receive a copy (Texas law establishes nominal fees for copy charges of medical records) of the information to be used and disclosed pursuant to this Authorization Form.

This Authorization is voluntary and I may refuse to sign this Authorization Form.

If I am providing authorization for marketing purposes, I understand that TDCJ may receive remuneration from a properly authorized business associate as a result of using or disclosing my PHI.

I understand that I am not required to sign this Authorization form in exchange for receiving treatment from TDCJ.

_____ _____
Signature of patient or personal representative Date

_____
Printed name of patient

_____
Printed name of personal representative (if applicable)

_____
Relationship of personal representative to the patient (if applicable)