TEXAS Health and Human Services

Case Management for Children and Pregnant Women

CM-12
8/22

Authorization to Disclose Protected Health Information (or other confidential information)

This authorization complies with the requirements of: Section 164.508 of the HIPAA Privacy Standards (45 CFR, Parts 160 and 164) and Occupations Code § 159.005 - Consent for Release of Confidential Information.

Name: _____
(Name of Individual)

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

I authorize the following person or entity:

_____
(Specify the Individual, Physician, Hospital, Clinic, Attorney, Counselor, School, Governmental entity, etc.)

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

to disclose the following specific health or other confidential information:

☐Yes ☐No Medical or Health Information. Indicate specific information if limiting:

☐Yes ☐No HIV-Related Information. Indicate specific information if limiting:

☐Yes ☐No Psychological Reports. Indicate specific information if limiting:

☐Yes ☐No Social History. Indicate specific information if limiting:

☐Yes ☐No Case Management Records Indicate specific information if limiting:

☐Yes ☐No Educational Plan Indicate specific information if limiting:

☐Yes ☐No Other. Indicate specific information if limiting:

To the following individual or entity:

_____
(Name or position of individual/entity authorized to receive information)

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

The information disclosed may be used by the individual/entity receiving the information for the following purpose:

_____

This authorization for release of information will end at the time case management services are discontinued or upon my request.

This form ☐was read **by** me ☐was read **to** me and I understand its purpose and content. All blanks were completed or struck through before I signed the form.

I understand that: 1) I may revoke this authorization in writing by contacting the HHSC 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.

_____
Signature of Individual or Personal Representative Date signed

_____
(Print / type name of Personal Representative, state their authority to act on behalf of individual. Attach documents to support.)

_____
(Address) (Telephone)

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. (Reference: Government Code, Sections 552.021, 552.023, 559.003 and 559.004)