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.
FACT will not withhold treatment, Medicaid benefits, or payment processing if you refuse to sign this authorization.
You will receive a copy of this signed authorization.

Individual	Case No.	DOB

I authorize the following facility or healthcare provider: (*name of facility/doctor, phone #, and fax #*)

FROM:	phone:	fax:

to disclose the following protected health information about me: (*description of the specific types of information, including time period covered*)

To the following person, facility or healthcare provider: (*name of person, organization, or doctor*)

TO:

The disclosure/use is for the following purpose(s):

- □ at my request
- □ for continuity of care
- □ to discuss with my family the care and treatment I receive
- □ other: _____

Notes:

- 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 this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.
- If you are signing as a parent/guardian/managing conservator of a minor or as a guardian 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 use 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)

Signature-Individual Date

Signature-Representative, if any Representative's relationship to individual Date

Ph: (512)733-8600
Fax: (512) 733-8602
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Georgetown: 3*201 South Austin Avenue, Suite 225, Georgetown, TX 78626*
Round Rock: *7700 Cat Hollow Dr, Ste 102, Round Rock, TX 78681*
Lakeway: *1310 FM 620 South, Suite A-14, Austin, TX 78734*
Taylor: *603 Mallard Lane, Suite A, Taylor, TX 76574*