Central Texas Mental Health

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Authorization for the Release of and Receipt of information primarily for family members/personal reasons.

I hereby authorize Dr. Michael Musgrove and his authorized representatives to disclose and/or obtain my individually identifiable health information as described below, which may include information concerning communicable disease such as HIV/AIDS, mental illnesses, chemical or alcohol dependency, laboratory results, medical history or treatment, or other such related information or materials. I understand this authorization is voluntary and I may refuse to sign. I understand my health care will not be affected if I do not sign this form.

Under HIPAA, it is important to know: **The Privacy Rule does not require the clinic to obtain a signed consent form before sharing information for treatment purposes.** Healthcare providers can freely share information for treatment purposes without a signed patient Healthcare providers can freely share information for treatment purposes without a signed patient authorization.

Information to be released (CHECK*)

☐ **ALL** ☐ **MEDICATION LISTS** ☐ **LABORATORY RESULTS** ☐ **OFFICE NOTES**

Above information can / may be released VERBALLY or in WRITTEN FORM to / from:

Family Members:

Others (CPS, County, Attorney, etc.):

Specific Doctors/Therapists ☐ Check box to send your medical chart to the provider(s) below:

I understand this authorization supersedes and revokes any and all authorizations previously on file. This authorization may not be interpreted as an addition to any previous authorizations on file.

I understand this authorization will expire in 365 days from the date of this authorization unless I specify another date.
I desire this authorization to expire on _____ *[if applicable].*

I understand I may revoke this authorization by issuing a written revocation to the office.

I acknowledge that there is no possible endangerment due to disclosure of my health information.

Patient's Signature:_____

Printed Name: _____ Date of Birth: _____

Today's Date : _____