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How to Complete Your Texas HIPAA Authorization

Authorization for Use and Disclosure of Protected Health Information (45 C.F.R. 164.508)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. Federal privacy law (HIPAA) limits who doctors, hospitals, and insurers can talk to about you. This authorization lets the people you name receive your health information so they can help you, even before they need to act as your agent.

1. **Your information (Page 1)**
   Enter your name, date of birth, and address.
2. **Who may receive it (Page 1)**
   Name each person who may receive your health information, such as your agents under your powers of attorney or family members.
3. **What and for how long (Page 1)**
   Choose what information may be released and when this authorization expires.
4. **Sign before a notary (Page 2)**
   Hospitals and insurers are more likely to accept a notarized authorization without question. Bring a current, government-issued photo ID.

After It's Signed

- Give copies to the people you named and to your doctors, hospitals, and health plans.
- You can revoke this authorization in writing at any time, except for information already released.
- This form works best alongside a Texas Medical Power of Attorney and Directive to Physicians. We have free forms for both.

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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**. Main headquarters: 2315 Capitol Avenue, Sacramento, CA 95816.

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HIPAA AUTHORIZATION

Authorization for Release of Protected Health Information (45 C.F.R. Section 164.508)

1. PATIENT

Full legal name

Date of birth

Address (street, city, state, ZIP)

Telephone

2. WHO MAY RELEASE INFORMATION

I authorize every physician, hospital, clinic, laboratory, pharmacy, health plan, insurer, and other covered entity or health care provider that has provided treatment, services, or payment to me to release my protected health information to the persons named in Section 3.

3. WHO MAY RECEIVE INFORMATION

Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone

4. INFORMATION TO BE RELEASED (check one)

☐ All of my health information, including medical records, test results, diagnoses, treatment, billing, and payment records.

☐ Only the following:

Unless I initial below, this authorization does **not** include psychotherapy notes or records of substance use disorder treatment. I separately authorize release of (initial each):

☐ Mental health records (other than psychotherapy notes)

☐ HIV/AIDS and other communicable disease information

☐ Substance use disorder treatment records

☐ Genetic testing information

Patient's initials: _____

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5. PURPOSE

At my request, to allow the persons named to discuss my care with my providers, assist with my health care and insurance matters, and, if applicable, carry out their duties under any power of attorney or advance directive I have signed.

6. EXPIRATION (check one)

This authorization expires two years after my death.

This authorization expires on the following date or event:

Date or event

7. MY RIGHTS

- I may revoke this authorization at any time by giving written notice to the provider or plan holding my information, except to the extent action has already been taken in reliance on it.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy rules.
- I am entitled to a copy of this authorization. A photocopy or electronic copy of this authorization is as valid as the original.
- This authorization is intended to qualify as a valid authorization under HIPAA and Texas law, and my agents under any medical power of attorney are to be treated as my personal representatives.

Date

X

Signature of patient (or personal representative)

Printed name

If signed by a personal representative, describe authority (e.g., agent under medical power of attorney, guardian)

NOTARY ACKNOWLEDGMENT

STATE OF TEXAS §

COUNTY OF §

This instrument was acknowledged before me on

Date

by (name of signer)

X

Notary Public, State of Texas

(Notary seal)

Notary's printed name

Notary ID number

My commission expires

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