dell children's
medical center of central texas
A member of the Seton Family of Hospitals

PATIENT LABEL

MENTAL HEALTH AUTHORIZATION FOR RELEASE OF PATIENT BEHAVIORAL HEALTH INFORMATION

I hereby authorize ***Dell Children's Medical Center*** to

_____ **Disclose to** _____ (Person/Entity)
_____ **Obtain from** _____ (Address)
_____ (City, State, Zip Code)
_____ (Telephone)
_____ (Fax Number)

My behavioral health information as described below. I understand that this authorization extends to all or any part of the records, which may include treatment for physical and mental illness (except for psychotherapy notes), chemical or alcohol dependency, communicable disease such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS") test results or diagnoses. I understand that my records may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws, and cannot be disclosed without my written consent at any time. I understand this consent is subject to revocation at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as indicated below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

Print Patient Name **Date of Birth** **Social Security Number**

Date(s) of Service (if known) **Medical Record #**

Description of information to be released: (Initial all that apply)

_____ Discharge Summary	_____ Admission Notes	_____ Billing/Financial Record
_____ Treatment Plan	_____ Progress Notes	_____ Medication Records
_____ Laboratory Reports	_____ Physician Progress Notes	_____ Physician Orders/Discharge
_____ Radiology Reports	_____ Mental Status Exam	_____ Verbal Communication with:
_____ Diagnostic Reports	_____ Psychological Testing	_____ (Name)
_____ Consultation Reports	_____ History & Physical Exam	_____ (Relationship)
_____ Other _____		

The purpose of the disclosure is for the following: ***(Initial the appropriate category)***

Patient Request:

_____ **Continuity of Care** _____ **Personal Information** _____ **Legal Purpose** _____ **School**
_____ **Insurance** _____ **Social Security/Disability Benefits**
_____ **Other: Please explain** _____

Hospital Request: _____

(If a hospital Request the patient must receive a copy of the authorization)

I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire **60 days** from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____

Expiration event/date

I hereby release Dell Children's Medical Center from all legal responsibilities or liability that may arise from disclosure of my medical records in reliance of this Authorization.

I understand that I may revoke this Authorization by requesting a written revocation of authorization form that can be obtained by calling/writing: ***4900 Mueller Blvd., Austin, Texas 78723, (512) 324-0000.*** I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Patient Signature **Date/Time**

Parent/Guardian Signature **Date/Time**

Print Last Name

Staff Member Witness Signature **Date/Time**