UNIVERSITY of HOUSTON

College of Liberal Arts and Social Sciences
Speech-Language-Hearing Clinic

Authorization For Release Of Protected Health Information

Patient Name: _____
Printed name: _____
Patient's Date of birth: _____
Address: _____
Telephone: _____

I, _____ (name of client or authorized representative), hereby authorize the University of Houston Speech Hearing and Language Clinic, A United Way Agency (USHLC), to obtain and disclose the protected health information described below for the following specific purposes:

Relevant Periods of Health Care
From (date) _____ to (date) _____

Please indicate type of information to be released - note all that apply
Billing _____
Progress notes and reports_____
History and diagnostic evaluation results _____
Diagnostic and treatment codes _____
Other (Specify) _____

Purpose of Request – note all that apply
Treatment or consultation _____
At request of patient _____
Billing or claims payment _____
Litigation _____
Other: (specify) _____

Who and Where to Send/Release Information:

Name: _____

Address: _____

Your initials are required to release the following information

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

Right to Revoke Authorization/Expiration
Unless action has already been taken in reliance on this authorization, I can revoke this authorization at any time by submitting a notice in writing to the Privacy Officer at USLHC. Unless revoked, this authorization will expire on the following date or event _____ or 180 days from the date of signature, whichever occurs sooner.

Representations

1. I understand that I do not have to sign this authorization, and that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

2. I understand that information used, disclosed or released in accordance with this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state health privacy regulations.

3. I hereby release the University of Houston, USHLC, and their respective employees, officers, health care providers and agents from any legal responsibility or liability for disclosure of the above information indicated and authorized herein.

Signature of Patient/Representative: _____

Name of Patient/Representative (printed): _____

Relationship to Patient: _____

Authority to Sign if not Patient: _____

Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE OF MINOR

X_____
Signature of Minor Individual

Date: _____

Identity of Requestor and Authority to Sign Verified by: _____
(USHLC representative)

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