mhmr tarrant
WE CHANGE LIVES

Case #: _____
Name: _____
Date of Birth: _____
SS #: _____
Medicaid #: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and request that:

Name: MHMR Tarrant
Address: 3840 Hulen Street, Suite 400
City, State, Zip: Fort Worth TX 76107
Phone: 817-569-4409, 4410, 4416, 4417, 4213, 5176
Email: Fax: 817-569-4494

Provide to / Receive from:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Email: _____

the following information which is limited to: *(Specify types of reports, type of communication requested)*

Psychiatric Evaluation, Medical, Progress Notes, Diagnosis and Drug/Alcohol

for the period of: (*Dates of treatment / period of time)* _____

Purpose or use of disclosure: _____

I authorize this information to be released in written and verbal form. If I am signing as a parent of a minor or guardian of a minor child, I further understand the record released may contain references to myself and family.

I understand my individually identifiable health information may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results medical history, treatment, or any such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form, unless I am receiving chemical dependency services. MHMR Tarrant may withhold treatment if I refuse to sign an authorization to disclose information necessary for the payment of chemical dependency services.

I understand that I may revoke this authorization at any time by notifying MHMR Tarrant, Health Information Management Department, in writing at 3840 Hulen Street, Suite 400, Fort Worth, Texas 76107. The revocation will not affect any actions taken before the receipt of the written revocation.

This authorization will expire one year from the date of this authorization unless I otherwise specify. This authorization expires: _____ *(not to exceed one year).*

Note: if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations. However, if you are receiving services for chemical dependency (drug or alcohol use), information about those services is protected from redisclosure by federal and state laws.

Individual/ Representative Signature: _____ Date: _____

Legally Authorized Representative's Relationship to Individual: _____

Witness: _____ Date: _____

A photocopy or facsimile of this authorization is as valid as the original.