Case #: _____

Medicaid #: _____

EMERGENCE HEALTH NETWORK

Consent to Release Information

1. The person whose information may be used, disclosed, or exchanged is:

   Name: (First, MI, Last):

   DOB:

2. I authorize the designated staff at Emergence Health Network to

   O disclose

   O use

   O receive

   protected health information about me.

   The information may be disclosed to/exchanged with this Agency and the Entity specified below:

   Entity is: O Configured for electronic exchange
   O Not configured for electronic exchange

   External Exchange Entity:

   Name: Phone:

   Address:

   City/State/Zip:

3. The information that may be disclosed/exchanged includes all records of diagnosis and treatment. Disclosure of psychotherapy notes is not permitted.

Additional disclosure limitations:

I also authorize the disclosure or receipt of my health information regarding (a selection is required to consent or deny the release of the following information):

O Yes O No Drug, Alcohol, or Substance Abuse Records
O Yes O No HIV/AIDS Records
O Yes O No Genetic Information (including Genetic Test Results)

4. This information is permitted to be disclosed/exchanged for treatment purposes only.

Additional details surrounding the purpose of information disclosure/exchange:

5. The persons or organizations receiving any Disclosure of this information will be prohibited by law from re-disclosing any information received based upon this consent and will be notified of that fact in every disclosure.

Case #: _____

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6. Consent:

   O I GIVE CONSENT for protected health information exchange
   O I DENY CONSENT for protected health information exchange

   Effective:

   Expires:

7. I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given

8. Is this request for the purpose of releasing records? O Yes O No

   I would like these records (check one):

   ☐ Emailed/Faxed_____

   ☐ Picked up at this location_____

   ☐ Picked up at Medical Records Office 1600 Montana, El Paso TX 79902

   ☐ By Mail (ALLOW 10 BUSINESS DAYS FOR THIS REQUEST)

   If different from the address above:OYesO No

   _____

I am the person or personal representative of the person whose records will be used, disclosed, or exchanged.
I give permission to use, disclose, and exchange records as described in this document.

I understand that Emergence Health Network (EHN) may share my health information in EHN's files with another medical provider to help with my treatment with that other provider with or without my permission as allowed under federal and state privacy laws (45 CFR 164.506(c)(4), Tex. Health and Safety Code 611.004(a)(7),
Tex. Health and Safety Code 81.103(b)(5)).

I understand that I do not have to give consent to share alcohol and/or substance abuse treatment information with my medical provider(s), but by authorizing disclosure on page one (1) of this form, I freely choose to do so. I also understand that I may revoke, at any time, my authorization for the medical provider(s) to have access to alcohol and/or substance abuse treatment information, however, other information regarding my treatment with EHN may be shared with the medical provider(s) as allowed under HIPAA and any other federal or state privacy laws. My decision to revoke this authorization shall only apply to information which has not already been
shared with the medical provider(s).

If there is any information in my medical record regarding current or past alcohol and/or substance abuse treatment, federal law prohibits EHN from sharing that information without my permission, unless in certain situations such as a medical emergency (42 CFR Part 2). The sharing of this information may be helpful to my medical provider(s) for my treatment.

I understand that my permission to share this information does not automatically mean that I have an alcohol or substance abuse problem, or that I have ever used or abused alcohol or drugs. Even though I may not have information in my medical record related to alcohol and/or substance abuse treatment, my permission to share this information will allow EHN to share my medical records quicker to my medical provider(s).

If I choose not to give permission to share alcohol and/or substance abuse treatment information, EHN will still provide my information to my medical provider(s), however, every document in my medical record will have to be reviewed to ensure that the substance and/or substance abuse treatment information is not shared.

I understand that the review of my medical record may require several hours and that an immediate turn-around cannot be guaranteed.

_____	_____	_____
Client/Guardian Print Name	Client/Guardian Signature	Date
_____	_____	_____
Staff Print Name/Title	Staff Signature	Date