Emergence Health Network
El Paso Center for Mental Health/Intellectual Disabilities

Client #:

Medicaid #:

Unit:

Consent to Release Information

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

   Client Name: DOB:

2. I authorize the designated staff at Emergence Health Network to Disclose, Use, or Receive my protected health information: (select only ONE of the following)

   ☐ Disclose ☐ Use ☐ Receive

3. Information to be disclosed to/exchanged with:

   Name: Address:

   City: State: Zip:

   Phone: Fax:

4. Information to be released/received/used:

   Covering the period(s) of treatment: From: To:

   ☐ Progress Notes: (make a selection below)
   - ☐ Medical Progress Notes
   - ☐ Caseworker Progress Notes
   - ☐ Therapy Progress Notes

   ☐ Psychiatric Evaluation
   ☐ Discharge Documentation
   ☐ Complete medical record
   ☐ Labs
   ☐ Billing Records

   ☐ Other (specify below)

   Mail Copies (complete address):

   Pick-Up copies (location of pick-up):

   Fax copies (attention to):

   E-mail copies:

5. 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):

   ☐ Yes ☐ No Alcohol or Substance Abuse Records

   ☐ Yes ☐ No HIV/AIDS Records

   ☐ Yes ☐ No Genetic Information (including Genetic Test Results)

6. Purpose of Receipt/Disclosure:

   ☐ at my request ☐ legal purposes ☐ billing and claims

   ☐ educational purposes ☐ treatment/continuity of care ☐ to verbally disclose the care and treatment I receive

   ☐ other:

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7. 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.

   This authorization will expire in (1) year from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by the following date:

   Effective Date: ______ Expiration Date: ______

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.

☐ I DENY CONSENT (Revoke)

I understand that EHN is sensitive about client's trauma and realizes the effects it can have. EHN encourages clients to participate in treatment decision making by giving them a voice and choice about the information that is shared with EHN and its staff. EHN promotes a trauma informed approach to its care and interactions with patients to reduce re-traumatization.

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.

Please allow 10 business days for your request

Client Signature:		**Date:**	
Parent/Guardian Signature: (*if not applicable, enter "N/A"*)		**Date:**	
LAR Signature: (*if not applicable, enter "N/A"*)		**Date:**	
Staff Name:		**Title:**	

For Office Use ONLY:

☐ Process Request (allow 10 business days) ☐ Upload into client's chart ONLY