Nueces Center for Mental Health and Intellectual Disabilities
Authorization for Use and Disclosure of Protected Health Information (rev. 09/2023)

Client Name: _____ Case #: _____

■The **purpose of this authorization** is: (check only one)

☐ Continuity of Care ☐ Disability Benefits ☐ At the Request of Patient ☐ Other: _____

Mark One Only ___ **Send my records to: Dates I received services: From _____thru _____**
___ **Request my records from: Dates I received services: From _____ thru _____**
___ **Disclose my PHI to: _____**
___ **Long Term Services and Support (LTSS) - your PHI will be shared with agencies or referral organizations that may help meet any potentially identified need for possible future health or Community based services**

(Name)_____(Relationship)_____
(Address/City/Zip Code)_____
(Telephone Number) _____(Fax Number)_____

PHI (Protected Health Information) to be released: (check as appropriate)

☐ Psychiatric/Psychological Evaluations ☐ History & Physical ☐ Medication List ☐ Assessments ☐ Laboratory/EKG results

☐ Discharge Summary ☐ Physician's Progress Notes ☐ Treatment Plan ☐ Social Worker Notes ☐ Release in Emergency Situation Only

☐ Diagnosis ☐ Other_____

REVOCATION: You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement or complete the Request for Action Concerning Protected Health Information Form, signed by you, to the Medical Record Administrator at 1546 S. Brownlee providing the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the facility. The revocation will not affect any actions taken before the receipt of the written revocation notice.

I have read/have been read to me and understand the terms of this Authorization. I have had an opportunity to ask questions about the use of disclosure of my protected health information.

Client Signature: _____ DOB: _____SSN: _____Date: _____

Signature of Legal Representative: _____Date of Signature:_____

Relationship of Representative to Consumer: _____
Staff Signature: _____ Staff ID: _____Date of Signature: _____

I **hereby authorize** the designated staff at **Nueces Center for Mental Health and Intellectual Disabilities** located at 1630 S. Brownlee Corpus Christi, Texas 78404 to Send/Request/Disclose my health information as listed above, which includes mental health/psychiatric information and may also include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), 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.

Consumer's Initials:	LAR's Initials:

□ Client/LAR refused to initial _____

EXPIRATION: To be valid, this form will expire on _____ (circle one) (not to exceed 180 days for requesting hospital records OR 365 days for all others.

I understand that if the recipient authorized to receive this information is not a covered entity as defined under federal privacy regulations, the disclosed information, except Chemical Dependency information, may no longer be protected by federal privacy regulations.

I understand that a copy or fax of this consent will be considered legal in lieu of original document.

Please initial that
____You received a copy.

Send my records to: Nueces Center for Mental Health and Intellectual Disabilities or Fax to 361 _____
c/o Medical Records
P.O. Box 71029, Corpus Christi, Texas 78467