Victoria County Public Health Department (VCPHD)
Authorization to Release Confidential Information

Name: ____

(Name of Client) (Date of Birth)

Address: ____

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

I authorize the following health care provider, attorney, counselor, school, etc.:

____

(Individual, Physician, Hospital, Clinic, Attorney, Counselor, School, etc.)

____

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

to release the following specific confidential information:

Yes ( ) No ( ) Medical Information. Indicate specific information:

____

Yes ( ) No ( ) HIV-Related Information. Indicate specific information:

____

Yes ( ) No ( ) Other. Indicate specific information:

____

to the following individual:

____

(Name or Position of Individual / Organization, if any represented)

____

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

The information released may be used by the individual, or the organization represented by the individual for the following purpose(s):

____

I understand that: 1) I may revoke this authorization in writing by contacting the VCCHD office or program that obtained the authorization; 2) this authorization will not affect treatment, payment, enrollment, or eligibility for benefits; and 3) information disclosed as a result of this authorization could be subject to re-disclosure as authorized by law.

EXPIRATION DATE: This authorization will expire on [date or event] ______________________________
(If no date or event is stated, expiration is one year from the signature date.)

This form (___) was read by me (___) was read to me and I understand its meaning. All the blanks were filled in before the form was signed by me.

____

Signature

____

(Print / Type Name of Person Authorized to Consent to Release of Information)

____

(Signature of Authorized Person)

____

(Address) (Telephone) (Date)

VCPHD FAX #: 361-485-9062

PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that we collect about you. You are entitled to receive and review the information upon request. You also have the right to ask VCPHD to correct any information that is determined to be incorrect. See http://www.tdh.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Victoria County Public Health Department (VCPHD)
Autorización para divulgar la información confidencial

Nombre: ____
(Nombre del cliente) (Fecha de Nacimiento)

Domicilio: ____
(Calle y número, apartado postal, número de *Rt. #*) (Ciudad) (Estado) (Código Postal)

Yo autorizo que el aquí inscrito, proveedor de servicios de salud, abogado, consejero, escuela, etc.,

____
(Individuo, médico, hospital, clínica, abogado, consejero, escuela, etc.)

____
(Calle y número, apartado postal, número de *Rt. #*) (Ciudad) (Estado) (Código Postal)

Que divulgue la siguiente información confidencial:

Sí ( ) No ( ) Información médica. Indique información específica:
____

Sí ( ) No ( ) Información sobre el Virus de Inmunodeficiencia Humana (VIH). Indique información específica:
____

Sí ( ) No ( ) Otra información. Indique información específica:
____

al siguiente individuo:

____
(Nombre o posición del individuo, de la organización, si acaso representa a alguna)

____
(Calle y número, apartado postal, número de *Rt. #*) (Ciudad) (Estado) (Código Postal)

La información divulgada podría ser usada por el individuo o, por la organización que el individuo representa, para los propósitos siguientes:
____

Yo entiendo y acepto que: 1) yo podría revocar por escrito esta autorización poniéndome en contacto con la oficina o programa de VCCHD que obtuvo la autorización; 2) esta autorización no afectará el tratamiento, pago, inscripción o, la elegibilidad para los beneficios y; 3) la información que se divulgue como resultado de esta autorización podría divulgarse nuevamente de acuerdo a la ley.

FECHA DE VENCIMIENTO: Esta autorización se vencerá [fecha o evento] ____
(si acaso no se declara fecha o evento, expira al año de la fecha en que fue firmada.)

Esta forma (___) yo la leí (___) se me leyó y, entiendo y acepto su significado. Todas las líneas en blanco fueron llenadas, antes de que yo firmara esta forma.

____
Firma

____
(Escriba con letra de molde o con máquina de escribir el nombre de la persona autorizada para acceder a la divulgación de la información)

____
(Firma de la persona autorizada)

____
(Dirección) (Número de teléfono) (Fecha)

VCPHD FAX #: 361-485-9062

Solo por unas cuantas excepciones, usted tiene el derecho de solicitar y obtener informacion de salud que el Departamento de Salud de Victoria y/o el Estado de Texas reúne sobre usted. Usted tiene el derecho de recibir y revisar la información al pedirle. Usted también tiene el derecho de pedir que la agencia corrija cualquier información que se ha determinado ser incorrecta. Diríjese a http://www.tdh.state.tx.us por más información sobre la Notificación sobre privacidad. (Referencia: *Government Code,* sección 552.021, 552.023, 559.003 y 559.004)

Instructions for Obtaining Consent to Release Medical Information
Victoria County Public Health Department (VCPHD)

Information contained in client records is confidential. With certain exceptions, the release of medical records is prohibited by the provisions of the Medical Practice Act (Article 4495b, V.T.C.S.). In addition, social, financial, educational and other types of information in client files may be protected by a constitutional or common law right to privacy. There are civil and criminal penalties for the unauthorized release of such information.

The Medical Practice Act, the common law and the Constitution permit a health care provider to release these types of information from an individual's record with the consent of the individual or a person authorized to consent for the individual. For example, the Medical Practice Act states:

> Occupations Code Sec. 159.005(a)(1-5) and (b). Consent for the release of confidential information must be in writing and signed by the patient, or a parent or legal guardian if the patient is a minor, or a legal guardian if the patient has been adjudicated incompetent to manage his personal affairs or an attorney ad litem appointed for the patient, as authorized by the Texas Mental Health Code; the Persons With Mental Retardation Act; Chapter XIII, Texas Probate Code, and Subtitle B Title 5, Family Code; or a personal representative if the patient is deceased, provided that the written consent specifies the following:
> (A) the information or medical records to be covered by the release;
> (B) the reasons or purposes for the release; and
> (C) the person to whom the information is to be released.

Further, the Communicable Disease Prevention and Control Act (Chapter 81, Health and Safety Code) contains the following specific requirements for the release of information relating to tests for AIDS, the human immunodeficiency virus (HIV), and antibodies to HIV:

> Sec. 81.103(d). An Authorization under this subsection must be in writing and signed by the person tested or the person legally authorized to consent to the test on the person's behalf. The authorization must state the person or class of persons to whom the test results may be released or disclosed.

The "Authorization to Release Confidential Information" form was developed to conform to these statutory requirements. For this reason, when you are requested to release information from records under your control, the form must be carefully completed to provide the information required by statute. If you are requested to provide information from a client record to an institution (e.g., a hospital) rather than an individual, and you do not know the name of the individual within the institution to whom the information is to be sent, insert the title of the responsible person (e.g., the administrator, medical records librarian, etc.). Do not simply insert the name of the hospital.

The "Authorization to Release Confidential Information" form must be completed and signed by individual clients when they request their personal health records be released.

The form may be used to obtain information from other providers and when used for that purpose, it should be completed with the same concern for the statutory, common law and constitutional requirements. Such attention to detail may ultimately save both time and effort.

The Medical Practices Act, the Communicable Disease Prevention and Control Act and certain other statutes, for instance, those relating for mental health and mental retardation information, provide several other exceptions to the rule of confidentiality relating to medical records.

ANY REQUEST FOR INFORMATION WHICH CANNOT BE ADDRESSED BY THE USE OF THE CONSENT TO RELEASE CONFIDENTIAL INFORMATION FORM MUST BE REFERRED IMMEDIATELY TO THE OFFICE OF GENERAL COUNSEL FOR NECESSARY ACTION. Because the Public Information Act and other statutes give a very limited time period during which the agency must respond to requests for information, any delay in making these referrals may lead to results which are adverse to the agency.

Please review the release form before releasing information. All blanks on the form must be filled in, the form must be read by the client, and the form must be appropriately signed before the information is released. The client must receive a signed copy of the authorization.