AUTHORIZATION TO DISCLOSE/OBTAIN PROTECTED HEALTH INFORMATION

The Menninger Clinic
12301 Main Street
Houston, TX. 77035
Ph.) 713.275.5000
Fax) 713.275.5108

I,____________________________________, ____________ DOB: ____________ hereby freely and voluntarily authorize
(Print name) (Patient ID #)

The Menninger Clinic to: (Check only one)

☐**Release/Disclose printed information to** ☐**Obtain written information from** ☐**Exchange Verbal Communication**

____
Name or Organization

____
Address **Phone Number**

____
City, State, Zip Code **FAX Number**

The reason for this disclosure is ____

My medical records may include information regarding diagnosis and treatment of **DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology), or PSYCHIATRIC DISORDERS**. I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that federal regulations (42 CFR part 2) prohibit their making any further disclosure without my written consent or as otherwise permitted by such regulations.

I specifically authorize the release or disclosure of the following **DESIGNATED** protected health information (PHI) and / or records, if such information and / or records exist

Discharge Summary	Psychological Testing	Billing Information
Neuropsychological Testing	Treatment Plan	Physician Orders
Eating Disorder Assessment	Addictions Assessment	Laboratory Reports
Psychiatric Evaluation/Assessment	Psychosocial Assessment	Entire Record
History and Physical	Outpatient Assessment	Other:___________________________

Service Dates to Disclose Records/or Specify Unit____
(ATP, CPAS, COMPASS, HOPE, PATHFINDER, PIC, OUTPATIENT SERVICES)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

All consents to release the medical record will expire **180 days** from date signed unless otherwise stated by patient. I wish to have this consent to expire on ____

I understand that I have the right to inspect and copy any written information disclosed and the right to revoke this consent at any time by giving written notice to The Menninger Clinic. **I UNDERSTAND REQUESTED COPIES WILL BE SUBJECT TO A REASONABLE FEE AS PROVIDED BY STATE LAW. ALL FEES WILL BE ON A PRE-PAY BASIS.**

I understand that I may not withdraw authorization for a disclosure that is necessary for the purpose of making payment to the hospital for services provided. I understand that federal law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by Menninger. Generally, we may not say to a person outside the facility that a patient is in the program or disclose any information identifying a patient as an alcohol or drug abuser unless:

a. The patient consents in writing by signing an authorization for the disclosure of information
b. The disclosure is allowed by court order
c. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or
d. Program evaluation. (42 CFR, chapter I part 2)

____ ______________
Patient/Parent Signature (if patient is a minor) or Legal Authorized Representative (LAR) **Date**

____ ______________
Witness **Date**

Menninger Clinic

Health Information Management
12301 Main Street
Houston, TX 77035
713-275-5000
Fax – 713-275-5108

RELEASE OF INFORMATION FEE SCHEDULE

In accordance to The State of Texas Health and Safety Code 241.154(e), the healthcare care information fee structure is as follows:

1 - 10 pages = $44.35
Pages 11 - 60 @ $1.49 per page
Pages 61 - 400 @ $.74 per page
Pages 400+ @ $0.39 per page

****Fees do not apply for information released to physicians or continuing care facilities.**

- Please allow 15 business days to complete all requests for Medical Records
- Invoice will be mailed after authorization is returned and pages have been counted.
- Medical Records cannot be faxed and will be mailed via US Postal Service at no charge
- If you desire overnight delivery, the actual cost of delivery will be added to your invoice.

October 29, 2012