AUTHORIZATION (HIPAA) TO RELEASE PROTECTED HEALTH INFORMATION ("PHI")

(For Use by Patient or Patient's Representative)

I, _____, the undersigned, do hereby authorize the use or disclosure of the Protected Health Information (hereinafter "PHI") as described below. By authorizing the use or disclosure of the PHI described below, I authorize Harris County, the Sheriff of Harris County, the Harris County Sheriff's Office, and its employees, agents and representatives (hereinafter "Custodian") to open the PHI for review or inspection by the person(s) identified below (hereinafter "Recipient"), and (2) to furnish the Recipient identified below with a copy of the PHI if he or she so requests.

Patient's Name:_____ **DOB:**_____ **SPN:**_____

Description of PHI to be released / disclosed, including dates of service: From: _____ to _____

- ☐ Medication Records / type and dosage
- ☐ Lab Reports / X-rays / MRI's and all other imaging studies
- ☐ Outpatient Records / E.R. Admissions / Doctor's Office
- ☐ Inpatient Records / Hospital Records
- ☐ Other: _____
  (Provide a specific and meaningful description of the information to be released)

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if the PHI described above contains the following sensitive information, I agree to its release:

Psychiatric care, psychotherapy notes, psychiatric or mental impairment.	Check one: ☐ Yes ☐ No
Drug and/or alcohol abuse.	Check one: ☐ Yes ☐ No
Sexually transmitted disease, HIV, AIDS, hepatitis B or C testing.	Check one: ☐ Yes ☐ No
Gene-related impairments including genetic test results.	Check one: ☐ Yes ☐ No
Sickle cell anemia.	Check one: ☐ Yes ☐ No
Other sensitive information.	Check one: ☐ Yes ☐ No

I authorize Custodian to release and/or disclose the PHI described above to the following Recipient:_____,at(address)_____.

The purpose of this request to release and/or disclose the PHI described above is:

- ☐ Referral and/or Treatment Purposes
- ☐ To file a claim
- ☐ Pending litigation
- ☐ Other

(describe)_____

I understand that the recipient of my PHI may redisclose my health information to third parties, and Custodian and recipient are under no obligation to prevent redisclosure of my information.

I understand that Custodian may not condition the provision of any services upon my completion of this authorization form. I understand that I have the right to revoke this Authorization at any time by written and dated notice to Custodian at 1200 Baker Street, Houston, Texas 77002. In the absence of any such revocation, this Authorization will expire on the following event or date _____ or 180 days from the date of signature, or upon release from jail, whichever is earlier.

_____ SSN: _____ Date: _____

Signature of Inmate-Patient

Witness: _____ Date: _____

By signing below, I certify that I am a *legally authorized representative* of Patient as that term is defined under the Texas Health & Safety Code, Sec. 241.151(5)[1]

_____ _____ Date:_____

Signature of Patient's Legally Authorized Representative *Name Printed*

[1] "[A] personal representative or heir of the patient, as defined by Section 3, Texas Probate Code … ."