HIPPA Authorization Form

Disclosure of Protected Health Information

I, *(Name)* _____, *(Date of Birth)* _____, *(SSN)* _____, authorize the disclosure of my protected health information* as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws**, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):
   + **All healthcare providers who have provided healthcare to me.**
2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organization(s) above.
   + **Claims Administrative Services, Inc.**
     P.O. Box 7500, Tyler, Texas 75711
   + **Texas Department of Insurance – Division of Workers' Compensation**
     7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1609
   + **Others: _____**
3. Specific description of the protected health information that I authorize for disclosure:
   + **Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnoses, tests, reports, or treatments.**
   + **I further specifically authorize the disclosure of psychotherapy notes, if any.**
4. The purpose of requesting this information is for use by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.
6. I understand that treatment and payment for my treatment are not conditioned on my agreement to this authorization.
7. I understand that the release of protected health information to a non-covered entity may invalidate its protection.
8. I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information related to such diagnosis, testing, or treatment.
9. This authorization expires one year from the date of authorization or the date that my workers' compensation claim is finally closed, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that this authorization is a true and correct statement of my intention to permit the disclosure of my PHI as described in this authorization.

Signature	**Date**

Name		
Address		
Phone Number	**SSN (Last 4 Digits Only)** **XXX-XX-**	**Date of Birth**

*Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse that relates to 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508 **These laws apply to health plans, health care providers, and health care clearinghouses.