[Your firm name and logo]

AUTHORIZATION TO RELEASE HEALTH INFORMATION (TEXAS)
Patient name: [Last, first, middle] | Other names: [ ] | Date of birth: [MM/DD/YYYY]
Address: [Street, city, TX ZIP] | Phone: [ ]
Released by: [Texas provider or facility name and address]
Released to: [Name of person or organization], [address], [phone]

Records covered
Records dated [start] through [end]: [ ] progress notes [ ] discharge summary [ ] operative and consultation reports [ ] lab and pathology reports [ ] radiology reports and images [ ] billing information [ ] other: [ ].

Initials required for these records
[Initials] mental health records, not psychotherapy notes. [Initials] genetic information and test results. [Initials] drug, alcohol or substance use records (a federally assisted program may require its own 42 CFR Part 2 consent; SUD counseling notes are not included). [Initials] HIV/AIDS test results or treatment. Records on lines without initials are excluded.

Why the records are needed
[ ] My own request [ ] Insurance: [policy or claim] [ ] Legal matter: [description] [ ] Other: [ ].

Electronic delivery
I [do / do not] authorize the provider to send these records to the recipient electronically. This authorization covers this one disclosure only.

End date
This authorization ends on [date], or earlier if [event], or when I withdraw it in writing.

Withdrawing permission
I can withdraw this authorization by written notice to [provider and records address]. Anything done in reliance on it before the provider receives my notice stays valid. If I signed it to obtain insurance coverage, other law may still give the insurer the right to contest a claim under the policy or the policy itself.

Your rights
Signing is voluntary. My care, payment, health plan enrollment and eligibility for benefits do not depend on it. Once released, the recipient could share the information again, and federal privacy rules might not protect it anymore. I may have a copy of this form.

Representative (optional)
Signed by [name], acting for the patient as [parent / guardian / medical power of attorney / executor], proof attached.

X _____ Date: [MM/DD/YYYY]
Signature of patient or legally authorized representative
Printed name: [ ]