

Tarnow Center for Self-Management
Authorization for Use and/or Disclosure of Patient Health Information

I Authorize: Tarnow Center for Self-Management [] To release and receive records to/from
 1001 West Loop South, #215 [] To only release mental health/medical records to
 Houston, Texas 77027 [] To only receive medical/mental health records from
 [] To share information verbally

If none of the above are checked, all apply

 Name of Recipient

 Address

 City State Zip Phone

Records and Information Pertaining To: (Please PRINT clearly)

Patient's Name: _____
 Last First Middle

Home Address: _____
 Street City Zip

Patient's Date of Birth: _____

Duration: This authorization shall become effective immediately and shall remain in effect until revoked in writing.

Revocation: This authorization is also subject to written revocation by the patient at any time. This written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Check the box [X] to specify which type of information is to be disclosed; then sign and date your selection.

	Signature	Date
[] All Mental Health Records	_____	_____
[] Psychiatric Information only	_____	_____
[] Treatment Plan/Testing Report	_____	_____
[] All of the above	_____	_____
[] Other Health Information:	_____	_____

The requested health information is authorized for the following purpose: _____

A copy of this authorization is as valid as the original/Patient has a right to a copy of this authorization.

Please indicate the means by which you want to obtain a copy of the requested information (fax, mail or pick up, etc.) and provide the necessary phone numbers or address(es) if different than shown above:

Mail Fax _____ Pick up Other

 Signature of patient 18 and older (or patient's representative) Date

 Printed name of patient (or patient's representative) Relationship to patient