kind CLINIC
A PROGRAM OF TEXAS HEALTH ACTION

CONSENT TO RELEASE INFORMATION (ROI)

Fax: 833-938-5463

Patient Full Name		**Patient Date of Birth**	

I authorize **KIND CLINIC** to ☐ **RELEASE** ☐ **OBTAIN** my protected health information to/from:

Name/Provider/Facility/Entity	**Phone Number**	**Fax Number**
Name/Provider/Facility/Entity	**Phone Number**	**Fax Number**

Health Information to be disclosed may include information related to:
☐ HIV/AIDS ☐ mental health ☐psychotherapy ☐ chemical/substance/alcohol abuse

Please release (choose one):
☐ My **complete** health record *(including but not limited to any treatment, conditions, medications, lab results)*

OR

☐ **Only** the items marked below (*Check all that apply)*

	Medications, Diagnosis & Treatment Summary including Diagnostics *(i.e. labs/imaging)*		Name of Service Provider(s) & Appointment Dates/Times
	Progress/Nursing Notes		Ryan White Eligibility Documentation *(includes HIV/AIDS related information)*
	Lab results including any pathology and genetic testing		Care plans including Case Management/ Social Worker notes & any special concerns or needs
	Any HIV/AIDS related information		Letters / Notes to patient or other entities
	Psychotherapy **and** Mental Health notes		Billing Records
	Chemical, Substance and/or Alcohol Abuse notes		Hospital/surgical records from other providers
	Other:		

I authorize release by any method necessary including electronic means (such as direct transmission, fax), and/or mail/paper *unless* otherwise noted here:_____

I authorize the release of all information related to care *unless* I specify a specific time frame:_____

This Authorization will remain in effect for **one year** *unless* I specify another date here:_____ or is otherwise revoked at a later time.

*By signing this form, I authorize **KIND CLINIC**, an entity of Texas Health Action, to release/obtain confidential health information about me to the physician/person/facility/entity as indicated above for disclosures related to the continuity of care, insurance/payors, legal, and/or personal use. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this authorization extends to all health information unless I specify limitations and may include records/reports from other health care providers involved in my care outside of Kind Clinic. I understand that my information will otherwise not be shared unless it is required and/or allowable by local/state/federal law. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and any payment for my health care will not be affected if I do not sign this form. I understand that in certain circumstances the revocation of this release may cause limitations to supportive services such as assistance programs and Ryan White.*

Further, it is my intent that a copy of this Authorization shall have the same effect as the original. I further understand that I may revoke this authorization at any time by notifying a Kind Clinic staff member or in writing mailed to 101 W Koenig Lane, Suite 300, Austin TX 78751. I also understand that any written revocation must be signed and dated with a date that is later than the date on this authorization. Any revocation will not affect any actions taken before the receipt of the revocation.

Printed Name of Patient or Patient's Representative: _____

***Relationship/ legal authority if not patient (may require supporting documentation)*:** _____

Signature ***Date***

Disclosure statement to the recipient of this authorization

This information to be disclosed may include records protected under applicable federal and state confidentiality laws, including HIPAA 45 CFR including Part 2, and Texas Health and Safety Code §85.115, where applicable. These regulations may prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person to whom it pertains or as otherwise legally permitted.