TRAVIS COUNTY ESD NO. 2 HIPAA AUTHORIZATION FORM

Patient's/Subject's Full Name	**Date of Accident or Incident for Which Records are Requested**
Address	**Patient's/Subject's Date of Birth**
City, State Zip Code	**Patient's/Subject's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me/my child:
   ____________Travis County Emergency Services District No. 2____
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/her/its Name

   Address

   City, State Zip Code
3. The specific information that should be disclosed is (please give date of accident or incident):

   ____

   ____

   ____

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION *______________________
   NO, **DO NOT** DISCLOSE THIS INFORMATION * ______________________
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Travis County ESD No. 2 in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for ____ .
7. This authorization expires on _____________, 20___, OR upon occurrence of the following event that relates to me/my child or to the purpose of the intended use or disclosure of information about me/my child: _____________________________________.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice if, in the opinion of the District, the copies are voluminous.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places if this Authorization is for a minor or is made on behalf of the estate of a deceased person.*

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signatory.

Official Use Only

Received	**Processed By**	**File #**