BEXAR COUNTY PUBLIC DEFENDER'S OFFICE
AUTHORIZATION FOR DISCLOSURE, USE, OR RECEIPT OF PROTECTED HEALTH INFORMATION

Participant's Name: _____ ID: _____
LAST FIRST MIDDLE

Social Security Number: _____ Date of Birth: _____

Home Address:_____
STREET CITY STATE ZIP CODE

Home Phone: (____) _____ Cell/Work Telephone Number: (____) _____

I hereby authorize the Bexar County Public Defender's Office to receive and/or disclose my protected health information from/to the following entities:

Alpha Home	Baptist Health System
Bexar County: Pretrial, Adult Probation	Center for Health Care Services: CLINICS/PROGRAMS
Bexar Sheriff's Department	Christus Santa Rosa Hospital
Haven for Hope	Laurel Ridge
Lifetime Recovery	Methodist Healthcare
Methodist Specialty	Northeast Baptist
San Antonio Police Department	Nix Specialty Health Center
Texas Department of Family and Protective Services	San Antonio Behavioral Healthcare Hospital
Texas Department of Health and Human Services	San Antonio State Hospital
Medical Provider:	Southwest General Hospital
Other Provider:	University Health Systems
Other:	**Emergency**:
Other:	

Description of item(s) to be released: (Check all that apply)

☐ Medical Diagnosis/Treatment/Medication Orders ☐ Nursing Notes ☐Laboratory Results_____
☐ Mental Health History/Treatment/Medication Orders ☐ Physician Progress Notes ☐ Income/Benefits
☐ Alcohol/Drug/Treatment ☐ Discharge Summary ☐ Employment/Unemployment
☐ Assessments_____ ☐ School Records/ARDs/IEP

The disclosure/use is for the following purpose(s):

☐Coordination of Care ☐ Assistance and Support of treatment ☐ To give information about my treatment and services ☐Legal

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- Note: If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.
- Note: If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family. You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the facility, except to the extent that the facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.
- **This authorization will be valid until for up to 30 days after my legal case closes to allow follow-up by case manager.**

_____ _____ _____ _____
Client Signature Date Bexar County Public Defender's Signature Date

_____ _____
Legal Representative/Guardian Date

A photocopy or facsimile transmission is as valid as the original.
(Note: For individuals receiving alcohol or drug abuse treatment, this form serves as the consent required by 42 CFR § S.31.)

Bexar County Public Defender's Office, 101 W. Nueva St., Suite 370, San Antonio, TX 78205
Phone: (210) 335-0701 Fax: (210) 335-0707

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