Authorization for Disclosure of Health Information

Would you like to have a *FREE Sexual Assault Advocate* present during your medical exam?

Advocates are provided by your local crisis center to give you counseling services and information about your rights. AN ADVOCATE IS STANDING BY TO HELP YOU. THIS SERVICE IS FREE, AND IT WILL NOT CAUSE YOU ADDITIONAL DELAY.

Please choose one option:

G Yes, I would like to talk to the sexual assault advocate who is standing by. ***Please fill out the form on the back side of this paper.***

G I do not want to talk to a sexual assault advocate right now, but I authorize the hospital to give the advocate my contact information, including my name, address, phone number(s), email address(es) and my preferred method(s) for contact so the crisis center can follow up later. ***Please fill out the form on the back side of this paper.***

G No, I do not wish any contact with the advocate or crisis center at this time. ***You do not need to fill out this form.***

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This form complies with the federal Health Insurance Portability and Accountability Act (HIPAA, 45 CFR 164.508) and applicable Texas law (Tex. Crim. Proc. Code §56.045, Tex. Health & Safety Code §241.152, and Tex. Occ. Code §159.005).

I, _____, voluntarily authorize the disclosure of information from my record under the following conditions:

The following hospital is authorized to make the disclosure:

Hospital: _____

Address: _____

City/State: _____

The requested information is to be disclosed to:

Crisis center or advocate: _____

Address: _____

City/State: _____

Statement of purpose: This disclosure is made to facilitate my access to a trained sexual assault advocate.

Description of information to be disclosed: Please see the choice indicated at the top of this form.

Right to revoke authorization in writing: I understand that I have the right to revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must present my written revocation to the health information management department of this hospital. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Expiration of authorization: If this authorization has not been revoked, it will terminate ONE YEAR from the date of my signature unless I have specified a different expiration date or expiration event. Expiration date if different: _____

Statement that benefits or treatment are not conditioned on authorization: I understand that this authorization is voluntary. I do not have to sign this form to ensure healthcare treatment. This hospital will not condition treatment or eligibility for care on my providing this authorization.

Statement of potential re-disclosure: I understand that once this information is disclosed, it may be re-disclosed by the recipient, and the information may no longer be protected by federal privacy laws including the Health Insurance Portability and Accountability Act Privacy Rule [45 C.F.R. 164].

Signature of Patient: _____ Date: _____

Signature of Parent, Guardian, or Authorized Representative if Patient is a Minor:

_____ Date: _____