. . . dedicated to helping the people we serve have a better life
HEALTHCARE TECHNOLOGIES, LLC

Authorization for Release of Protected Health Information (PHI) from GHT, LLC to External Parties

1. **I authorize Guinn Healthcare Technologies, LLC to disclose confidential information including Protected Health Information (PHI) from the records maintained by Guinn Healthcare Technologies, LLC from the confidential records of:**

		☐ Male ☐ Female	XXX-XX-
Patient Name	*Date of Birth*	*Gender*	*SSN Last Four*

2. **The information is to be disclosed to:**

Organization/Person Name:

Street:

City: *State:* *Zip:*

Contact Person: (if known)

Phone (if known): *Fax (if known):*

I authorize this information to be disclosed in the following ways:

☐ Written/Photocopy/Paper ☐ Electronic Format ☐ Verbal ☐ Fax

Specific information to be disclosed:

☐ my name and other personal identifying information
☐ initial evaluation
☐ date of admission
☐ assessment results
☐ summary of treatment plan
☐ progress and compliance with treatment attendance
☐ date of discharge and discharge status
☐ discharge plan
☐ employment and training related information
☐ Other: (list) ____________________

3. Purpose of Disclosure:
The purpose of these disclosures is to enable the identified entities to provide or receive information related to assisting with treatment, evaluating and responding to participation and progress, determining my readiness/ability to participate in work, or *other purposes (if other purposes, please describe):*

(Over)

Clinic Office:
Resource Connection ~ 2300 Circle Drive, Suite 2307 ~ Fort Worth, TX 76119
Phone: (817) 349-8787 ~ Fax: (817) 231-0650
www.guinntech.com

4. For Substance Abuse Clients:
I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not rescind this consent, it expires automatically as follows:

- upon my termination from Guinn Healthcare Technologies, LLC Mental Health and Social Services Programs or three years from the date this consent is signed or the date specified (whichever comes first)

5. For Mental Health Clients:
I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not rescind this consent, it expires automatically as follows:

- upon my termination from Guinn Healthcare Technologies, LLC Mental Health and Social Services Programs or three years from the date this consent is signed or the date specified (whichever comes first)

6. Acknowledgements - I understand the following:

- My treatment (or the patient's treatment) will not be based on the completion of this authorization form.

- It is possible that the information to be released by this authorization may be re-released by the person or organization that receives it, and may no longer be protected by Federal or Texas privacy regulations.

Patient Consenter Section			
______________________________ Patient Printed Name	XXX-XX-_ _ _ _ SSN Last 4	___/___/___ Date	______________________________ Patient Signature ★(if patient is a minor, must be signed by parent or guardian)
Parent/Guardian/Consenter Section (If applicable) - ☐ N/A			
______________________________ Parent/Guardian Printed Name	XXX-XX-_ _ _ _ SSN Last 4	___/___/___ Date	______________________________ Parent/Guardian Signature
______________________________ Relationship of Parent /Guardian's to patient listed above: (e.g.; mother, grandmother, father, child welfare agency, etc.)		______________________________ Specific Status Enabling the Consenter to Release Information (managing conservator, parent, etc)	___/___/___ Date
Consent End Date			
Consent End Date: (if a date is provided in the designated space, this consent will expire on the date specified, if no date is provided in this section, the consent will expire 3 years from the date of client signature)			___/___/___
GHT Staff Signature			
Staff Signature ______________________________ ___/___/___			

To the party receiving this information: Substance Abuse information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.