Menninger
Where healing comes to mind

AUTHORIZATION TO DISCLOSE/OBTAIN PROTECTED HEALTH INFORMATION

The Menninger Clinic
12301 Main Street
Houston, TX. 77035
Phone) 713.275.5000
Fax) 713.275.5108

Please read this entire form. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. Authorization may not be required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **COPIES WILL BE SUBJECT TO A REASONABLE FEE AS PROVIDED BY STATE LAW.**

I, _____, _____ DOB: _____ hereby freely and voluntarily authorize
Print Name **Patient ID #**

The Menninger Clinic to:

☐ Release/Disclose printed information to ☐ Obtain written information from ☐ Exchange Verbal Communication with

Name or Organization:_____
(Except for organizations with a treating provider relationship with the patient and third-party payors, individual(s)' name(s) must be provided for release of Substance Use Disorder Information under Box 4)

Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number:_____ Fax Number:_____ Email:_____

1. The information is needed for: *(check at least one option)*:
☐ Treatment ☐ Disability ☐ Billing /Claims ☐ Legal ☐ Continuity of care ☐ Other: _____

2. Method of delivery: (*check only one option*): ☐ Mail ☐ Fax ☐ Email

3. Information to be released or accessed: I specifically authorize either (depending on my selection above) (1) the release or disclosure or (2) verbal communication regarding the following designated protected health information (PHI) and / or records, if such information and / or records exist from _____ to _____ *Default will be current encounter only, unless specified
Date Date

Medical record abstract
- ☐ Psychiatric Discharge Summary
- ☐ Comprehensive Psychiatric Evaluation
- ☐ Psychosocial Assessment
- ☐ History and Physical
- ☐ Psychological/Neuropsychological Testing
- ☐ Addictions Assessment
- ☐ **All of the above**

Additional records
- ☐ Laboratory Reports
- ☐ Genetic Information
- ☐ Master Treatment Plan
- ☐ ECT Notes
- ☐ Eating Disorder Assessment
- ☐ HIV/AIDS Test Results
- ☐ **All of the above**

- ☐ Executive Summary/Outpatient Services
- ☐ Medication List
- ☐ Entire Record (excluding psychotherapy notes, substance abuse records and raw psychological test data)
- ☐ Billing/Financial Information
- ☐ Other:_____
_____

4. Substance Use Disorder Information: (Optional) By initialing below, I explicitly authorize in accordance with 42 C.F.R. Part 2 the release/disclosure of alcohol, drug, and substance abuse information if present in my protected health information, including, if present, diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summaries, employment information, living situation and social supports, and claims and encounter data. I understand that if I do not authorize disclosure of alcohol, drug, and substance abuse information, much or all of my protected health information may not be released.

☐ I authorize disclosure of all of my substance use disorder information (patient initials required).

5. Effective time period: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional) _____.

6. Right to revoke: I understand that I can withdraw my permission at any time by giving written notice by certified mail stating my intent to revoke this authorization to the person or organization named above and to The Menninger Clinic. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

7. SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that my medical records may include information regarding diagnosis and treatment of **DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology), or PSYCHIATRIC DISORDERS**. I understand that such information is confidential and is protected by federal law. I understand that refusing to sign this form does not stop disclosure of health information that already has occurred or that is otherwise permitted by law without my specific permission, including disclosures as provided by Texas Health & Safety Code § 181.154(c), 45 C.F.R. § 164.502(a)(1), and/or 45 C.F.R. 164.512(a). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient (unless re-disclosure is prohibited by law) and may no longer be protected by federal or state privacy laws. I understand that I may inspect or copy any information to be used or disclosed under this authorization.

_____ _____
Patient/Parent Signature (if patient is a minor) or Legal Authorized Representative* **Date**
*Photo identification will be requested to verify your identity. The patient's initials in Box 4 and signature are required for the release of substance use disorder information.

_____ _____
Minor's Signature** **Date**
**If the patient is a minor, the minor individual's initials in Box 4 and signature are required for the release of substance use disorder information.

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Fee Schedule for Medical Records

Patients and Families:

There is no charge for medical record via e-mail or fax (first encounter).

$45.00 for paper copies of medical record
$45.00 for second copy of encounter

Authorized Representatives/Attorneys/Third Party:

Medical record via e-mail, fax, upload or portal
$45.00

Paper copies of medical record

In accordance to The State of Texas Health and Safety Code 241.154(e), the healthcare information fee structure is as follows:
1-10 pages = $46.61
Pages 11-60 @ $1.57 per page
Pages 61-400 @ $0.77 per page
Pages 401 + remaining pages @ $0.42 per page
plus $5.00 shipping supplies

- Fees do not apply to information released to physicians or continuing care facilities.
- Please allow 15 business days to complete all requests for medical records.
- Invoice will be sent after completed authorization is received.
- Medical records will be e-mailed, faxed, uploaded or mailed when payment is received.
- If you desire overnight delivery, the actual cost of delivery will be added to your invoice.