TEXAS HEALTH AND HUMAN SERVICES COMMISSION

May 2004

AUTHORIZATION FOR USE AND RELEASE OF HEALTH INFORMATION

SECTION I

Name_____ D.O.B._____ Medicaid ID# (if known)_____

SSN#_____

By signing this authorization form, you are giving the Texas Health and Human Services Commission (HHSC) permission to release all or part of your Medicaid claims history, which includes health information.

SECTION II – To be completed by Client

I authorize HHSC and/or it's business associate to release the information indicated in Part A below to the person or agency named in Part A below, for the purpose(s) stated in Part B below. My information will remain available to the person or agency indicated until the expiration date stated in Part B. I understand that I have the right to revoke this consent at any time, provided that the revocation is in writing to the requesting attorney, unless records have already been released, or authorization was obtained as a condition of obtaining insurance coverage. Once the information is used or disclosed it may be subject to re-disclosure by the recipient and is no longer protected under 45 CFR 164.508.

Part A – Release of information: I understand that my Medicaid claims history contains protected health information.

Check one of the following:

Release all of my Medicaid claims history
Release only the parts of my Medicaid claims history that relate to:

- **the following health care provider: _____**
- **other (please describe in detail the health information you authorize HHSC to release):**

_____

_____

Release my information to the following Person/Agency: XL Record Service PO Box 153736 Lufkin, TX 75915

On behalf of (Atty or Lawfirm if applicable):_____

Part B - Purpose(s) of Release: Litigation

This authorization expires on: _____

Part C - Signature: _____ Date: _____

(Client or Personal Representative's Signature)

If you are signing for the client, please describe your authority to act for the client on the following line:

_____

Note: If the person requesting the release of my Medicaid claims history cannot sign his/her name, a witness to his/her mark (X) must sign below:

_____ _____

Witness **Date**: