Texas Physician Health Program

1801 Congress Ave, Suite 9-500, Austin, Texas 78701 Phone: (512) 305-7462 Fax: (512) 463-0216 www.txphp.texas.gov

Consent to Release Protected Health Information to TXPHP

Name of TXPHP Participant: _____Date of Birth: _____
Address: _____
City, State, Zip: _____
Phone #: _____Email:_____

Name of individual/entity to release records: _____
Address: _____
City, State, Zip: _____
Phone #: _____Email:_____

I hereby authorize and request that the healthcare provider, facility, or other individual or entity listed above release the following protected health information to TXPHP:

- ☐ All medical records related to my care and treatment
- ☐ Mental health records
- ☐ Discharge summary
- ☐ Assessment/evaluation findings
- ☐ Alcohol & drug treatment records and screening reports
- ☐ Other Click here to enter text.

I release and hold harmless the above listed individual or entity and associated physician(s), hospital(s), treatment center(s), or other healthcare provider(s), their members, agents, or employees from any and all claims for damages arising out of or related to the release of the information specified above.

I agree that TXPHP may communicate with the individual or entity listed above regarding my care and treatment, as well as other applicable services related to my impairment or participation in TXPHP.

I understand this authorization is voluntary.

I understand that TXPHP, to whom this information is sent, may re-disclose the information to its agents, employees, and others connected to TXPHP, including the TMB, should TXPHP be authorized to do so under law. TXPHP will not disclose this information without statutory authorization.

The information provided herein and in response to this authorization is confidential and I understand that I may not have a right of access to the protected health information provided to TXPHP.

I understand that I have the right to withdraw this authorization at any time and that this authorization shall expire without my written revocation five (5) years from the date of my signature below.

Date: _____

Participant's Signature: _____

DISCLAIMER: TXPHP is NOT a healthcare provider and will not sign a HIPAA Business Associate Agreement if requested to do so.

SEND DOCUMENTS TO:
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Austin, Texas 78701
Fax: (512) 463-0216
Email: info@txphp.state.tx.us