Bluebonnet Trails Community Services
Bluebonnet Trails Community Services
1009 N. Georgetown Street Round Rock, Tx 78664
Phone#: 512-244-8214 or 512-244-8217 Fax #:512-853-7066

Authorization to Disclosure, Use, or Receipt of Protected Health Information

Client Name: ______________________ Case #: ______________
Date of Birth: ______________________ SSN#: ______________

1. *I authorize the designated staff at Bluebonnet Trails Community Services
   * County name: ____________

   ☐ Disclose ☐ Use ☐ Receive the following protected health information about me

   *Information to be released (**at least one box must be checked**):

   ☐ All Records
   ☐ Assessments & Evaluations ☐ Developmental/Social History
   ☐ Psychological/DMR/ D&E ☐ Medications
   ☐ Behavior & Progress in School ☐ Counseling Records
   ☐ Other: ________________ ☐ Summary of Treatment (Diagnosis, Treatment Plans, Progress Notes)

   Describe specific types of information and date range of information requested:______________________________

   Information to be excluded (please write in specific information not be released or requested): ______________________

   The designated staff may disclose to or from:

   ____
   *Name of person/organization/facility **(must be specified)** Relationship

   ____
   Address, City, State, Zip Telephone # Fax #

   *For the purpose of (**check all that apply**):
   Reason for disclosure
   ☐ to coordinate discharge planning/placement ☐ to assist in educational placement
   ☐ at my request to ☐ to assist in addition funding
   ☐ outcome measurement
   ☐ to discuss with family the care and treatment I receive at:______________________
   ☐ other:______________________

2. If I am signing as a parent/guardian/managing conservator of a minor or guardian of the person of an adult, I understand the information disclosed/used/received may contain references to my family and myself.

3. *I also authorize the disclosure/use/receipt of my health information regarding:
   Alcohol and Drug Abuse Treatment ☐ Yes ☐ No
   Note: Except for information related to drug and alcohol abuse treatment, the information disclosed pursuant to this authorization may not be protected by medical privacy laws and may be subject to re-disclosure by the recipient.

4. I understand that I have the right to revoke this authorization. To revoke this authorization, I must deliver a written statement, signed by me, to Bluebonnet Trails Community Services, which provides the date and purpose of this authorization and my intent to revoke it. The effective date is the date which it is received by the Bluebonnet Trails Community Services. I understand that this revocation will not apply to information that has already been released as described in the Notice of Privacy Practices. Unless otherwise indicated, this authorization will expire on: ____________. Authorizations without a specified expiration date or revocation will expire when your services are discontinued with Bluebonnet Trails Community Services.

5. I have the right to refuse to sign this authorization. Bluebonnet Trails Community Services will not withhold treatment, Medicaid benefits, or payment processing if I refuse to sign the authorization. You will receive a copy of this authorization.

6. *AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION VIA E-MAIL
   I have indicated my preference regarding sharing of this information by e-mail and I have reviewed the potential risk factors related to exchange of information using e-mail on the back of this page.
   ☐ Yes ☐ No Email information to be sent to: ______________________

____
Signature of Client or Legal Representative If signed by Legal Representative, Relationship to Client Date of Request

____
Signature of Witness Date

(Note: For individuals receiving alcohol or drug abuse treatment, this form serves as the consent required by 42 CFR, Part 2.31)

***all items with asterisk must be filled to be a valid consent**

POTENTIAL RISKS RELATED TO PROVIDER E-MAIL COMMUNICATIONS

1. E-mail can be altered, forwarded, intercepted, printed, and stored by others without detection.

2. If the provider is unable or unwilling to follow the directions to establish a password allowing them to unencrypt the e-mail, they will be unable to receive the information by e-mail. BTCS will not send protected health information through e-mail without encryption.

3. Unintentional errors in entering e-mail addresses could result in your information being sent to the wrong person.

4. There may be a greater time lapse before the recipient is aware of or responds to e-mailed information than there would be for faxed or hard copy formats.

5. Should the e-mail provided in the Send To section of this form not exist or not be monitored regularly, we have no way of knowing how to secure an updated e-mail address unless you provide further contact information for the person, such as a telephone number or mailing address.