



**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**  
La Hacienda Treatment Center, P.O. Box 1, Hunt, TX 78024, Phone: (800) 749-6160, Fax: (830) 238-6119

**Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.**

**Patient Name** \_\_\_\_\_  
 Last First Middle

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone** (\_\_\_\_) \_\_\_\_\_ **Date of Birth** Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**I authorize La Hacienda Treatment Center to disclose the patient's Protected Health Information to the following Designee:**

**Person/Healthcare Organization Name** \_\_\_\_\_  
 (Form must indicate a specific person's name to disclose information to unless it is a Healthcare provider relationship)

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone** (\_\_\_\_) \_\_\_\_\_ **Fax** (\_\_\_\_) \_\_\_\_\_

**Secure Email** \_\_\_\_\_

**Reason for Disclosure** (check one)       Personal Use       Treatment/Continuing Medical Care  
 Legal Purposes       Other: \_\_\_\_\_

**The following information is to be disclosed for the dates of treatment:** \_\_\_\_\_ to \_\_\_\_\_  
(If no dates are indicated, your most recent treatment records will be disclosed)

**I authorize the following information to be disclosed:**

- Inpatient - All Treatment Records       Inpatient Program Attendance Letter (includes admission/discharge dates and discharge status)
- Intensive Outpatient (IOP) - All Treatment Records       IOP Attendance Letter (includes admission/discharge dates and discharge status)
- Assessments (includes History and Physical, Bio-Psychosocial Assessment, Pre-Admission Screening)
- Laboratory/Radiology Reports (includes Drug Screen/Breathalyzer/EKG/Other Test Results)
- Progress Notes (includes Physician, Clinical, and Nursing)
- Psychiatric/Psychological Assessments/Testing/Notes       Master Treatment Plan and Treatment Plan Review
- Physician Orders       Discharge Summary
- Medication List       Continuing Care Plan
- SASSI Results       Other: \_\_\_\_\_

**EXPIRATION:** This authorization will expire **180 days (6 months)** from the date of my signature, or specified as follows: \_\_\_\_\_

**RE-DISCLOSURE:** Federal law prohibits the person or organization to which disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted or required by law.

**REVOCACTION:** I understand that I may revoke this authorization at any time by notifying La Hacienda Treatment Center, except to the extent that action has been taken in reliance on it.

**DISCLAIMER:** I understand that information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired Immunodeficiency Syndrome ("AIDS") or Human Immunodeficiency Virus ("HIV") infection; (2) treatment for drug and/or alcohol abuse; and/or (3) mental or behavioral health or psychiatric care. **I agree to this disclosure.**

\_\_\_\_\_  
 Patient Signature/or Personal Representative      Date