AUTHORIZATION TO DISCLOSE PRE-ADMISSION LETTERS

La Hacienda Treatment Center, P.O. Box 1, Hunt, TX 78024, Phone: (800) 749-6160, Fax: (830) 483-2232

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
☐ Legal Purposes
☐ Treatment/Continuing Medical Care
☐ Other: _____

I authorize the following information to be disclosed:

☐ Letter of intended screening
☐ Letter of scheduled admission

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.
REVOCATION: 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 will 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