AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

**Information regarding the patient for whom authorization is made:**
Full Name: _____Date of Birth: _____
Address:_____ City:_____ State:_____ Zip Code:_____
Phone: (_____)_____

**Information regarding health care provider authorized to disclose this information:**
Name: _____
Address:_____City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Fax: (_____)_____

**Information regarding person or entity who can receive and use this information:**
Name: iChange Counseling and Psychiatry, Dr. Dorian Aponte
Address: 604N Bell Ave, Denton, TX 76209
Phone: (940) 448-0304 Fax: (972) 364-1189

**Specific information to be disclosed:**
□ Medical Record from (insert date) _____ to (insert date) _____
□ Entire Medical Record
□ Other: _____

| **Include: (*Indicate by Initialing*)** | **Reason for release of information:** |
|---|---|
| _____ Drug, Alcohol or Substance Abuse Records | ***(Choose all that Apply)*** |
| _____ Mental Health Records (Except Psychotherapy Notes) | □ Treatment/Continuing Medical Care |
| _____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results) | □ Billing or Claims |
| _____ Genetic Information (Including Genetic Test Results) | □ Legal Purposes |
| | □ Other *(Specify)*: _____ |

This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
**Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: _____
**Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Patient/Legal Representative: _____ Date:_____
If Legal Representative, relationship to Patient: _____

A minor individual's signature is required for the release of certain types of information, including for example, reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____