Guinn . . . dedicated to helping the people we serve have a better life
HEALTHCARE TECHNOLOGIES, LLC

Authorization for Release of Protected Health Information (PHI) from External Entities to GHT, LLC

1. I authorize the following organization/person(s) to disclose confidential information including Protected Health Information (PHI) from records pertaining to the following individual:

Patient Name:

		☐ Male ☐ Female	XXX-XX-
Patient Name	*Date of Birth*	*Gender*	*SSN Last Four*

Organization requested to release information:

Organization/Person Name:

Street:

City: *State:* *Zip:*

Contact Person: (if known)

Phone (if known): *Fax (if known):*

2. The information is to be disclosed to the following organization/person:

GHT Staff Name:

Organization: *Guinn Healthcare Technologies, LLC*
2300 Circle Dr, Suite 2307
Fort Worth, TX 76119
Phone: 817 349-8787 *Fax: 817 231-0650*

I authorize this information to be disclosed in the following ways:

☐ Written/Photocopy/Paper ☐ Electronic Format ☐ Verbal ☐ Fax

Specific information to be disclosed:

☐ my name and other personal identifying information
☐ initial evaluation
☐ date of admission
☐ assessment results
☐ summary of treatment plan
☐ progress and compliance with treatment attendance
☐ date of discharge and discharge status
☐ discharge plan
☐ employment and training related information
☐ Other: (list) _____

(Over)

3. Purpose of Disclosure:
The purpose of these disclosures is to enable the identified entities to provide or receive information related to assisting with treatment, evaluating and responding to participation and progress, determining my readiness/ability to participate in work, or *other purposes (if other purposes, please describe):*

4. For Substance Abuse Clients:
I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not rescind this consent, it expires automatically as follows:

- three years from the date this consent is signed or the date specified (whichever comes first)

5. For Mental Health Clients:
I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not rescind this consent, it expires automatically as follows:

- three years from the date this consent is signed or the date specified (whichever comes first)

6. Acknowledgements - I understand the following:

- My treatment (or the patient's treatment) will not be based on the completion of this authorization form.
- It is possible that the information to be released by this authorization may be re-released by the person or organization that receives it, and may no longer be protected by Federal or Texas privacy regulations.

Patient Consenter Section

_____	XXX-XX-_ _ _ _	___/___/___	_____
Patient Printed Name	SSN Last 4	Date	Patient Signature ★(if patient is a minor, must be signed by parent or guardian)

Parent/Guardian/Consenter Section (If applicable) - ☐ N/A

_____	XXX-XX-_ _ _ _	___/___/___	_____
Parent/Guardian Printed Name	SSN Last 4	Date	Parent/Guardian Signature

_____ Relationship of Parent /Guardian's to patient listed above: (e.g.; mother, grandmother, father, child welfare agency, etc.)

_____ Specific Status Enabling the Consenter to Release Information (managing conservator, parent, etc)

Consent End Date

Consent End Date: (if a date is provided in the designated space, this consent will expire on the date specified, if no date is provided in this section, the consent will expire 3 years from the date of client signature) ___/___/___

GHT Staff Signature

Staff Signature _____ ___/___/___