Resident Name: _____
Last First MI Previous Name, if any

DOB:_____ SS#_____ Phone: _____ _____
Home Cell

Resident Address: _____
Street City State Zip Code

I authorize _____ to disclose to Tuskegee Airmen Texas State Veterans Home

Address: 2200 Joe B. Rushing Road Fort Worth Texas 76119
Street City State Zip Code

Phone: 817-502-6001 Fax: 817-502-1441 Email: _____

Covering the periods of healthcare from (date) _____ to (date)_____

For the purpose of: _____
(If requested by the patient, state "At the request of the Individual")

Method of disclosure: ☐ Mail ☐ Verbal ☐ Pick Up ☐ Fax ☐ Email

The following information may be released: (ex. clinical summaries, lab reports, nurses' notes, or all medical records)

_____

I give specific authorization to disclose the following information as well as documents that contain reference to:

_____ HIV test results and documentation of AIDS diagnosis
_____ Drug and alcohol abuse treatment records
_____ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying the facility in writing.

Completion of this authorization form will not affect my treatment, payments, or eligibility for benefits. As a patient, I have the right to access my clinical records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand 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.

Unless revoked earlier, this authorization expires upon this date or event: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient (or Patient Representative) Authority of Representative to act for Patient

For Office Use: Identity Verified by _____