Magnolia STRONG
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817.921.3001 (F)

1307 8th Avenue, Suite 201
Fort Worth, TX 76104

Release of Information

Patient Name: _____ Treating Physician _____
Date of Birth: _____ Phone Number: _____
Address: _____ City _____ State _____ Zip _____

I, _____, hereby authorize Magnolia Rehabilitation to disclose my protected health information to:

Name: _____
Business/Organization: _____
Address: _____
Phone: _____ Fax: _____

Purpose of Disclosure:

- ☐ Changing Physicians
- ☐ Consultation
- ☐ Insurance/Worker's Comp
- ☐ Disability Claim
- ☐ Other (specify)_____

I understand that releasing this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below. I understand that I may revoke this authorization at any time by notifying Magnolia Strong Rehabilitation in writing, but if I do, it will not have any effect on any actions Magnolia Strong Rehabilitation took before receiving the revocation.

I hereby authorize Magnolia Strong Rehabilitation to release the following information, which may include mental health records (check all that apply):

- ☐ Evaluation Reports
- ☐ Treatment Plan(s)
- ☐ Progress Notes/Reports
- ☐ Clinical records used to make benefit determinations
- ☐ All records relating to a Disability, insurance/Worker's Compensation claims
- ☐ Other (describe):_____

Acknowledgement of understanding and agreement:

Patient/Legal Representative Name (Printed): _____ Relationship: _____

Patient/Legal Representative Signature: _____ Date: _____

HIPAA Privacy/Confidentiality Notice: Magnolia Strong- is a HIPAA – compliant entity. The document(s) accompanying this fax contains confidential Protected Health Information (PHI) intended only for the use on the recipient or institution named above. The covered entity receiving the PHI assumes the full responsibility of maintaining the privacy and security outlined by HIPAA. If you are not the intended recipient, or cannot comply with HIPAA Privacy, Security and Transaction Rule guidelines, then you are hereby notified than any readying, disclosure, copying, distribution or taking any action in reliance on the contents of the copies information except as direct delivery to the intended recipient named above is strictly prohibited under the HIPAA Privacy rule. If you