TEXAS Health and Human Services

Form 6700
August 2017-E

Use and Release of Health Information Authorization

Section I

Name: _____ Date of Birth: _____

Medicaid ID No. (*if known*): _____ **OR** SS No.: _____

By signing this authorization form, you are giving Texas Health and Human Services (HHS) permission to release all or part of your Medicaid claims history, which includes health information.

Section II – To be completed by client

I authorize HHS to release the information indicated at the bottom of Part A to the person or agency named in Part A, for the purpose(s) stated in Part B. My information will remain available to the person or agency indicated until the expiration date stated in Part B.

Part A – Release of information: I understand that my Medicaid claims history contains protected health information.

Check one of the following:

- ☐ Release **all** of my Medicaid claims history
- ☐ Release **only** the claims related to the accident and/or injury
- ☐ Release **only** the parts of my Medicaid claims history that relate to:
  - the following health care provider: _____
  - other (please describe in detail the health information you authorize HHSC to release):

_____

Release my information to the following Person/Agency: _____

Part B – Purpose(s) of Release: _____

This release expires six months following the final disposition of the claim or upon disposition of Medicaid funds.

Part C – Signature: _____ Date: _____

(Client or Personal Representative's Signature)

If you are signing for the client, please describe your authority to act for the client on the following line:

_____

Note: *If the person requesting the release of my Medicaid claims history cannot sign his/her name, a witness to his/her mark (X) must sign below:*

Witness: _____ Date: _____

Section III: Notices to Client

- Once you authorize HHS to release your information, HHS is not responsible for any redisclosure of the information by the recipient.
- You can withdraw permission you have given HHSC to use or disclose health information that identifies you, unless HHSC has already taken action based on your permission. You must withdraw your permission in writing.
- With a few exceptions, you have the right to request and be informed about the information that the HHS releases. You are entitled to receive and review the information upon request. You also have the right to ask HHS to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). If you would like HHSC to correct information about you that is incorrect, please contact the HHSC Privacy Office at 4900 N. Lamar Blvd., 4th Floor, Austin, Texas 78751.