COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
Phone: 972-548-5500
Fax: 972-548-4441

Collin County Health Care Services (CCHCS)
Authorization of Release of Protected Health Information (PHI)

Patient Name (Last, First, Middle):	DOB:		Gender: ☐ Male ☐ Female
Address:	City:	State:	Zip Code:

I authorize Collin County Health Care Services to **release** PHI to the following individual/agency.

The following CCHCS clinic will release PHI:	PHI should be released to:
☐ Communicable Disease (STD)	Name: ______________________ (Individual, Physician, Hospital, Clinic, etc.)
☐ Elimination (TB)	Address: ______________________
☐ Employee Health	______________________
☐ Immunizations	Phone: ______________________
☐ Substance Abuse	Fax: ______________________
☐ All CCHCS Clinics	

Method of Release*¹: ☐ In-Person Pick-Up ☐ Mail ☐ Fax*²

*¹Please allow 10 business days for release to be completed. *²STD/HIV records cannot be faxed.

Date Range: ______________________ to ______________________ ☐All Time

This request and authorization extends to ONLY:

☐ Immunization Record
☐ Laboratory Results
☐ Imaging/Radiology Reports
☐ Information pertaining to the following condition, injury or treatment: ______________________
☐ All medical information pertaining to patient (entire medical record)
☐ Other (Specify): ______________________

I understand that the PHI maintained by CCHCS for the patient named above is confidential, protected by HIPAA, and cannot be disclosed without specific written authorization except otherwise provided by law. I hereby voluntarily request and authorize records to be released. I understand that I may revoke this authorization at any time by presenting my written revocation to CCHCS, Attention: Privacy Officer, 835 N. McDonald St., Ste. 130, McKinney, TX, 75069. I understand the revocation will not apply to information that has already been released under this authorization. This authorization shall be in effect until my written revocation is received by CCHCS or for one year following the date that this release was signed.

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION

This information has been disclosed to you from records whose confidentiality is protected. Laws and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains. CCHCS and the individual(s) named above are hereby released form any legal responsibility and liability for disclosure of the information as noted above if disclosure is in accordance with this authorization.

Name of Requestor: ______________________ Requestor's Signature: ______________________

Requestor's Relationship to Patient: ______________________ Date: ______________________

CCHCS Approver Signature: ______________________