The Arc of San Antonio
Serving People with Intellectual and Developmental Disabilities

Authorization to Disclose Protected Health Information
(or other confidential information)

This authorization complies with the requirements of:
Section 164.508 of the HIPAA Privacy Standards (45 CFR, Parts 160 and 164)
and Occupations Code § 159.005 – Consent for Release of Confidential Information.

Name: _____
(Name of Individual)

Address: _____
(Street Number, Post office, route number) (City) (State) (Zip Code)

I authorize the following person or entity:

_____
(Specify the Individual, Physician, Hospital, Clinic)

_____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

To disclose the following specific health or other confidential information:

☐Yes ☐No Medical or Health Information. Indicate specific information if limiting:

☐Yes ☐No HIV – Related Information. Indicate specific information if limiting:

☐Yes ☐No Psychological Reports. Indicate specific information if limiting:

To the following individual or entity:

Jeanne Calvert RN, CCN - The Arc of San Antonio
(Name or position of individual/entity authorized to receive information)

13430 West Avenue, San Antonio, TX 78216 jcalvert@arc-sa.org (210) 490-4300 Extension 138
(Street Number, Post Office) (City) (State) (Zip Code) (Email) (Phone)

The information disclosed may be used by the individual/entity receiving the information for the following purpose:
General nursing care of the Named individual, to include medication administration (Rx and PRN), G-tube feeding and Nebulizer treatments, if ordered by medical provider.

This authorization for release of information will end one year from today, or services are discontinued or upon my request.
This form ☐ was read by me ☐ was read to me and I understand its purpose and content. All blanks were completed or struck through before I signed the form.
I understand that: 1) I may revoke this authorization in writing by contacting The Arc of San Antonio. 2) This authorization will not affect treatment, payment, enrollment, or eligibility for benefits; and 3) information disclosed as a result of this authorization could be subject to re-disclosure as authorized by law.

_____
Signature of Individual or Personal Representative Date Signed

_____
(Print/type name of Personal Representative, state their authority to act on behalf of individual. Attach documents to support.)

_____
(Address) (Telephone)