TEXAS
Health and Human Services

Form H1826
November 2021-E

Case Information Release

Case Name: _____ Case No: _____

I authorize HHSC to release information from my case record to the following person or agency for the purpose(s) stated below. My information will remain available to the person or agency indicated until the expiration date provided below.

Release of information: I understand that my case record may contain protected health information. Release my information to the following person or agency:

To confirm HHSC has the right to use or disclose your PHI or case facts to the person you designated above, HHSC will ask that person for their name, address, and phone number as it appears on this form or a form of identification that HHSC may use to help us: (1) know if we are providing your information to the right person and (2) keep your facts private.

Check one of the following to indicate the information for release:

- ☐ Current status of benefits
- ☐ All information used to determine eligibility (may include protected health information)
- ☐ Copies of notices
- ☐ Other information, please specify:

Purpose(s) of Release: (i.e. – Treatment/Continuing Care, Insurance, Disability Determination, etc.)

This authorization will expire (check one and fill out):

- ☐ This date: _____
- ☐ After this amount of time: _____
- ☐ When the following event related to the patient takes place, and is made known by the person signing below to HHSC:

_____

- ☐ When I notify HHSC in writing that I have withdrawn this release and it is no longer in effect.

Statement of Understanding and Signature:

- By filling out and signing this form, I am allowing HHSC to disclose confidential information or case facts to the person listed above.
- If I authorize HHSC to share health facts that are part of this case record, those health facts are no longer protected by state or federal privacy laws. After HHSC discloses the PHI or case facts to the person or organization listed above, the information may be re-disclosed by the recipient and is no longer protected by state and federal privacy protections.
- I have given a description of the PHI or identified case facts that will be disclosed on this form.
- I am not required to sign this form to apply for or get benefits, receive treatment, or receive payment from HHSC for myself, or the person for whom I have a legal right to act.

Signature:

_____ _____
Signature (Person whose information will be released or their authorized representative) Date

☐ If you are signing for the person, please describe your authority to act on their behalf on the following line.

Note: A copy of the documentation to support your authority to act may be requested.

If the person requesting the release of case information cannot sign their name, two witnesses to their mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason witness signatures are needed in the case record.

Witness: _____ Date: _____

Witness: _____ Date: _____

Notice to Client

- Once you authorize HHSC to release your information, HHSC is not responsible for any redisclosure of the information by the recipient.
- You can withdraw permission you have given HHSC to disclose confidential or protected 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 Texas Health and Human Services Commission (HHSC) obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect. If you would like HHSC to correct information about you that is incorrect, please contact your local eligibility determination office.