TEXAS
Health and Human Services

Form H1836-B
January 2006-E

Medical Release/Physician's Statement

Section I - To Be Completed By Staff

Name of Patient	Date of Birth	Social Security No.
Case Name (caregiver)	Case No.	Patient's Usual Job
Advisor's Name	BJN	
Office Address/Mail Code		Office Fax No.

Section II - To Be Completed By Physician

The person caring for the patient named above has applied for benefits with our agency. Federal and state regulations require that persons receiving benefits work or participate in activities to prepare them for work unless they are unable to do so due to a circumstance such as being needed in the home due to the patient's disabling illness or injury. This person claims that circumstance. Please complete parts A and B below. After you complete the form, you may give it to the person or mail it to HHSC at the address in Section I.

Part A – Caring For a Disabled Family Member

To what extent is the caregiver able to work or participate in activities to prepare for work? Please check **one** of the following boxes:

☐ 1. The caregiver is able to work, or participate in activities to prepare for work (outside or inside of their home), full time

☐ 2. ☐ (a) The caregiver is able to work or participate in activities to prepare for work (outside of their home), part time at ___ hours/week

☐ (b) The caregiver is able to work or participate in activities to prepare for work (inside of their home), part time at ___ hours/week

☐ 3. The caregiver is unable to work or participate in activities. If you check this box, please indicate which of the following applies:

☐ (a) The disability is permanent.

☐ (b) The disability is not permanent and is expected to last more than 6 months.

☐ (c) The disability is not permanent and is expected to last 6 months or less.

If necessary, provide further detail: _____

_____

_____

Part B – Diagnosis

Primary disabling diagnosis	Secondary disabling diagnosis

Comments: _____

_____

_____

_____

Name of Physician (please type or print)	Physicians License No.	Signature - Physician	Date

Office Address (Street or P.O. Box, City, State, ZIP)	Area Code and Telephone No.

Authorization to Release Medical Information

Section III – To Be Completed By Patient or Patient's Personal Representative

Patient's Name _____

The applicant is requesting an exemption from participating in the employment services program because he/she is needed in the home due to your disabling illness or injury. When you sign this authorization, you are giving HHSC permission to contact your doctors, medical facilities or other health care providers to request copies of you health information as indicated below. You must sign this form if you want the applicant to be eligible for an exemption from the employment services program.

I authorize _____

Doctor, Medical Facilities or other Health Care Providers

to complete Form H1836-B, Medical Release/Physician's Statement, and release the information to HHSC and the Texas Workforce Commission for purposes of verifying that the applicant is needed in the home due to my disabling illness or injury, and therefore cannot participate fully in the employment services program.

This authorization expires on _____

_____ _____
Patient or Personal Representative's Signature Date

If you are signing for the patient, please describe your authority to act for the patient:

_____

_____

Note: If the person requesting the release of case information cannot sign his/her name, two witnesses to his/her mark (X) must sign below:

_____ _____
Witness Date

_____ _____
Witness Date

Notice to Client

HHSC, as receiver of this information, will protect your personal health information in accordance with federal and state privacy regulations. If you authorize release of your health information to other parties, it may no longer be protected by privacy regulations.

You can withdraw permission you have given your doctor or health care provider to use or disclose health information that identifies you, unless they have already taken action based on your permission. You must withdraw your permission in writing.