



Medical Information Release/Disability Determination

Mail Code | HHSC Staff | Fax No. | Date

Applicant Name | Date of Birth | Social Security No. | Application/Case No.

PART I - The above applicant or the applicant's authorized representative is applying for one of the state assistance programs listed in the Texas Health and Safety Code, §161.202. Thus, health care providers and health care facilities may not charge the applicant or the applicant's authorized representative a fee to provide medical or mental health records.

Check here if applicant is a veteran.

PART II - Medical Information Release

SECTION I - Completed by HHSC

Applicant's Name | DOB

This person is applying for disability benefits from HHSC. Disability eligibility is based on federal Social Security disability guidelines. This applicant alleges he or she is disabled due to the following medical/mental conditions:

SECTION II - Completed by applicant's or applicant's authorized representative

HHSC is requesting verification of your medical needs to determine your eligibility for services. When you sign this authorization, you are giving HHSC permission to contact your doctors, medical facilities, other health care providers or government agencies to request copies of your health information as indicated below. Your signature is required on this authorization form to determine your eligibility for services.

I, (Print Applicant's Name)

authorize (check all that apply) to release any medical records pertaining to the above mentioned medical/mental conditions to HHSC.

- Social Security Administration, DARS, Veterans Administration, Other, Doctor, medical facilities or other health care providers. List all:

This authorization expires on:

Signature Applicant or Authorized Representative | Date

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

NOTE: If the person requesting the release of case information cannot sign his or her name, one witness to his or her mark (X) must sign below:

Witness | Date

SECTION III - Notice to Applicant

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.