RESOLUTIONS
WELLNESS GROUP

Authorization for Release of Information

CONFIDENTIAL – PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION — COMPLETE ALL FIELDS

Full Legal Name (Last, First, Mi):

_____

Date of Birth: _____ Chart/Medical Record#: _____ Social Security # (Last 4): ___ – ___

Date of Request: _____ Expiration Date of This Authorization: _____

If no expiration date is specified, this authorization will expire one (1) year from the date of signature, or upon occurrence of a specified event, whichever is earlier.

SECTION 1 — IMPORTANT NOTICE TO PATIENT: PLEASE READ CAREFULLY BEFORE SIGNING

Instructions:

YOUR RIGHTS REGARDING THIS AUTHORIZATION

This form authorizes the release of your health information. Your records at Resolutions Wellness Group may include information about substance use disorder (SUD) treatment, mental health treatment, psychiatric medications, and medical history.

SPECIAL FEDERAL PROTECTION — 42 CFR PART 2

Records related to your substance use disorder (SUD) treatment are protected by a federal law called 42 CFR Part 2. This law provides stronger protections than standard HIPAA. Under 42 CFR Part 2, your SUD treatment records CANNOT be shared with anyone — including other healthcare providers, employers, law enforcement, courts, or family members — without your written authorization, EXCEPT in a medical emergency or when required by a court order specifically authorizing the release.

By signing this form, you are voluntarily choosing to allow us to release information that is otherwise strictly protected by federal law. You have the right to refuse to sign and the right to revoke this authorization at any time. Refusing to sign or revoking this authorization will not affect your treatment, payment, or enrollment in services — with limited exceptions noted below.

TEXAS MENTAL HEALTH RECORDS

Records related to your mental health treatment are also protected under Texas Health and Safety Code §611. You have the right to control who accesses these records.

YOUR RIGHTS UNDER THIS AUTHORIZATION

· You have the right to refuse to sign this authorization.

· You have the right to revoke this authorization at any time in writing. Revocation takes effect upon receipt.

· You have the right to receive a copy of this completed form.

· Signing this form is voluntary. Your treatment will not be conditioned on signing this authorization, UNLESS the purpose of the disclosure is related to research, or to obtain health care solely for the purpose of creating health information for a third party.

· Information disclosed pursuant to this authorization may no longer be protected by HIPAA or 42 CFR Part 2 once it is received by the party listed in Section 4, unless that party is also a HIPAA covered entity or is independently bound by 42 CFR Part 2.

SECTION 2 — PATIENT / AUTHORIZED REPRESENTATIVE INFORMATION

2.1 Patient information

Legal Full Name:_____

Date of Birth: _____

Address:_____

City:_____ State:_____ ZIP:_____

Phone : _____ Email: _____

2.2 Authorized Representative (Complete only if patient ia a minaor, incapacitated or deceased)

Representative Name: _____

Relationship to Patient: _____

Legal authority (check one):

____ Parent / Guardian ____ Legal Guardian ____ Healthcare Proxy ____ Power of Attorney

____ Personal Representative of Deceased Patient ____ Other: _____

Documentation of authority on file: ____Yes ____ No — Attached herewith: ____Yes

SECTION 3 — PARTY RELEASING INFORMATION (FROM)

3.1 Select direction of information exchange

Resolutions Wellness Group is RELEASING information TO the party listed in Section 4

Resolutions Wellness Group is RECEIVING information FROM the party listed in Section 4

Bidirectional — Resolutions Wellness Group may both release and receive information with the party listed in Section 4 .

3.2 Resolutions Wellness Group — Clinic Information (Pre-filled by staff)

Facility Name: **Resolutions Wellness Group**

Address: _____

City: _____

State: **TX** ZIP: _____

Phone: _____

Fax: _____

SECTION 4 — PARTY RECEIVING / SENDING INFORMATION (TO / FROM)

Name of Individual or Organization: _____

Specific Provider Name (if applicable): _____

Role / Relationship of Recipient (check all that apply):

____ Primary Care Provider ____ Specialist ____ Hospital / Emergency Room ____ Pharmacy

____ Mental Health Provider

Substance Use Treatment Program:

____ Insurance / Payor ____ Attorney ____ Employer ____ Court / Probation / Parole ____ Drug Court

____ Family Member ____ CPS / DFPS ____ School / Educational Institution

Other: _____

Address:_____

City:_____ State:_____ ZIP:_____

Phone : _____ Email: _____(If applicable)

SECTION 5 — INFORMATION AUTHORIZED FOR RELEASE

5.1 Type of Records (Check all that apply)

General medical records (history and physical, lab results, imaging, medications).

Psychiatric evaluation and mental health records .

Psychotherapy / counseling notes (Note: psychotherapy process notes require a separate authorization under HIPAA — 45 CFR §164.508(a)(2))

Medication management records (psychiatric medications)

Substance use disorder treatment records — INCLUDING MAT/MOUD records (42 CFR Part 2 applies — Section 6 initials REQUIRED)

Urine drug screen (UDS) results

Toxicology / laboratory results

Intake assessment and evaluation

Treatment plan

Progress notes / follow-up visit notes

Discharge summary

Referral documentation

Billing records / itemized statement

Prescription history

Other: _____

5.2 Date Range of Records Requeste

All records on file

Records from: _____to:_____

Most recent visit only

Specific records: _____

5.3 Requested Format of Release

____ Paper printed copy ____Secure electronic / encrypted fax ____ Electronic health record portal

____ CD / USB ____ Other:_____

SECTION 6 — 42 CFR PART 2: SUBSTANCE USE DISORDER RECORD DISCLOSURE

THIS SECTION IS REQUIRED when any SUD treatment records — including MAT/MOUD records, addiction counseling notes, UDS results in the context of SUD treatment, or any records that identify a person as having a substance use disorder — are included in this release. If SUD records are not included, mark "No" below and proceed to Section 7

MANDATORY NOTICE REQUIRED BY FEDERAL LAW — 42 CFR §2.32

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Does this release include SUD treatment records?

YES — 42 CFR Part 2 applies. Patient initials below are REQUIRED before release.
NO — SUD records are not included. Proceed to Section 7.

Patient Acknowledgment of 42 CFR Part 2 Disclosure:
I understand and authorize the release of my substance use disorder treatment records, including MAT/MOUD records, as specified in Section 5. I understand these records are protected by 42 CFR Part 2 and that this written authorization is required for their release. I understand that the recipient is prohibited from re-disclosing these records without my further written consent or as otherwise permitted by law.

Patient Initials:_____ Date_____

6.1 Recipient's Permitted Use of SUD Records (Required by 42 CFR Part 2 — specify all that apply)

Federal law requires that the purpose of the disclosure be stated. The receiving party may only use the records for the purpose(s) specified below.

Continuity of medical care
Mental health treatment coordination
Insurance / billing purposes
Court / legal proceeding — specify:_____
Drug court / probation monitoring
DFPS / CPS coordination
Research (requires additional IRB / program approval per 42 CFR §2.52)
Other (specify): _____

6.2 Re-Disclosure Prohibition Notice

The receiving party listed in Section 4 is hereby notified that ***re-disclosure of SUD treatment records is strictly prohibited*** without specific written authorization from the patient or as otherwise expressly permitted by 42 CFR Part 2. Any unauthorized redisclosure may be subject to criminal penalties under federal law (42 CFR §2.3).

6.3 Expiration of 42 CFR Part 2 Authorization

Note: An open-ended or indefinite authorization is not permitted for SUD records under 42 CFR Part 2. An expiration date or expiration event is required.

Expiration date for SUD record disclosure:_____
Upon occurrence of the following event:_____

SECTION 7 — PURPOSE OF DISCLOSURE

Why is this information being released? ***(Check all that apply)***

____ Continuity of care / treatment coordination
____ Referral to specialist or treatment program
____ Psychiatric evaluation or medication management
____ Primary care coordination
____ Insurance / prior authorization / billing
____ Legal proceedings — specify:_____
____ Drug court / probation / parole compliance
____ CPS / DFPS / child custody proceeding
____ Disability determination (SSA / employer)
____ Employment verification ***(Note: SUD diagnosis CANNOT be disclosed to an employer without explicit 42 CFR Part 2 authorization per Section 6 above)***
____ School or educational institution
____ Personal copy for patient records
____ Family communication — specify relationship and information to be shared:_____
_____
____ Research or quality improvement ***(requires additional authorization)***
____ Other:_____

SECTION 8 — EXPIRATION OF THIS AUTHORIZATION

This authorization will expire on the **earliest** of the following **(select one or more)**:

____ Specific date:_____
____ Upon occurrence of the following event:_____
____ One (1) year from the date of signature **(default if no date or event specified; does not apply to 42 CFR Part 2 records)**
____ Upon completion of the specific purpose described in Section 7.

42 CFR Part 2 Note: An expiration date or expiration event must be specified for any authorization covering SUD records. A separate expiration entry is provided in Section 6.3

SECTION 9 — LIMITATIONS, EXCLUSIONS & SPECIAL INSTRUCTIONS

Are there any specific limitations on what may be released?
No limitations — release all items checked in Section 5
Yes — the following information is **EXCLUDED** from this release:

Special instructions to Resolutions Wellness Group staff:

9.1 HIV / AIDS Test Results (Texas Health and Safety Code §81.103)

Note: Under Texas Health and Safety Code §81.103, HIV/AIDS test results require a **separate written authorization** and may **not** be included in a general records release unless specifically authorized below.

I specifically authorize the release of **HIV** / **AIDS** test results as part of this authorization.

Patient Initials:_____ Date_____

9.2 Genetic Information (GINA / Texas Law)

Note: Genetic information is protected under the Genetic Information Nondiscrimination Act (GINA) and Texas law. Genetic test results may **not** be released to health insurers or employers. Specific authorization is required below.
I specifically authorize the release of **genetic information** as part of this authorization.

Patient Initials:_____ Date_____

SECTION 10 — RIGHT TO REVOKE THIS AUTHORIZATION

You have the right to r**evoke this authorization at any time** by submitting a written revocation to Resolutions Wellness Group. Revocation becomes effective upon receipt by the clinic and does **not** apply to disclosures already made in reliance on this authorization prior to receipt of the revocation.

Revocation will **not** affect your right to treatment, enrollment in services, or insurance coverage, except where the authorization was given as a condition of obtaining insurance or research-related care.

To revoke this authorization, submit a written request to:

Resolutions Wellness Group
Attn: Medical Records / Privacy Officer Address: _____
Phone: _____Fax: _____

SECTION 11 — FEES FOR RECORDS

Release of records may be subject to reasonable copying and processing fees consistent with **Texas Health and Safety Code §241.154** and applicable state and federal regulations.

Patient authorizes payment of reasonable fees for records release.

Estimated fee (if known): _____
Fee waived: ____ Yes ____No - Reason:_____

SECTION 12 — STAFF USE ONLY: PROCESSING LOG

(Do not write in this section — for clinic use only)

Request received by: _____ **Date received:** _____
Records verified and pulled by: _____ **Date:** _____
Records released by: _____ **Date released:** _____

Method of release:
____ Fax ____ Secure encrypted email ____ US Mail ____ In-person pickup ____ EHR portal

Fax confirmation #: _____ **Tracking # (if mailed):** _____
Total pages released: _____ **Records date range released:** _____

42 CFR Part 2 re-disclosure notice included with release: ____ Yes N/A — SUD records not released

Copy provided to patient: ____ Yes ____ No
Supervisor review (if required): _____ **Date:** _____

Notes: _____
_____

SECTION 13 — PATIENT SIGNATURE AND ACKNOWLEDGMENT

By signing below, I confirm and attest that:

- I have read and understand this Authorization for Release of Information, including all42 CFR Part 2 and HIPAA notices.
- I am voluntarily authorizing the release of the information specified in Section 5 above.
- I understand my right to refuse to sign and my right to revoke this authorization at
- any time in writing (see Section 10).
- I understand that information disclosed pursuant to this authorization may no longer be protected by HIPAA or 42 CFR Part 2 once received by the party listed in Section 4, unless that party is also a HIPAA covered entity or is independently bound by 42 CFR Part 2.
- I have received, or have been offered, a copy of this completed authorization form.
- I understand that this authorization was not required as a condition of my treatment, payment, or enrollment in services, unless otherwise specifically indicated in this form.

Patient Signature: _____ Date:_____

Printed Name: _____

Authorized Representative Signature (Complete only if applicable — see Section 2.2)

Authorized Representative Signature: _____ Date:_____

Printed Name Relationship to Patient: _____

Witness Signature: _____

Witness Signature Date: _____

Printed Name Role / Title: _____

SECTION 14 — REVOCATION RECORD *(Staff Use Only)*

Use this section to document any written revocations received from the patient or authorized representative. Revocation takes effect upon receipt.

Date Received	Revocation Method (Mail / Fax / In-Person/Other)	Staff Initials	Record / Disclosures Affected	Notes

SECTION 15 — AUTHORIZATION LOG

(For Standing / Recurring Authorizations — Staff Use Only)

Use this section to log each disclosure made under a standing or recurring authorization. Maintain a complete record of all uses. Patient should be notified of each disclosure in accordance with clinic policy.

Date Used	Records Released to (Individual / Organization)	Record Type(s)	Pages	Staff Initials	Patient Notified (Yes/ No/ Method)

Legal Compliance Reference: This form is designed to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164; 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records, as amended by the CARES Act 2020 and the 2024 Final Rule); Texas Health and Safety Code §611 (Mental Health Records); Texas Health and Safety Code §241 (Hospital Records); Texas Health and Safety Code §81.103 (HIV/AIDS Confidentiality); the Genetic Information Nondiscrimination Act (GINA); and all applicable Texas Department of State Health Services regulations.

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Privacy Officer Approval Required Before Use.

This form is intended for use by Resolutions Wellness Group and its authorized staff only. It is not a substitute for legal advice. Consult qualified legal counsel for guidance on specific compliance questions.