

Instructions for Obtaining Consent to Release Medical Information

Information contained in client records is confidential. With certain exceptions, the release of medical records is prohibited by the provisions of the *Medical Practice Act* (Article 4495b, V.T.C.S.). In addition, social, financial, educational and other types of information in client files may be protected by a constitutional or common law right to privacy. There are civil and criminal penalties for the unauthorized release of such information.

The *Medical Practice Act*, the common law and the Constitution permit a health care provider to release these types of information from an individual's records with the consent of the individual or a person authorized to consent for the individual. For example, the *Medical Practice Act* states:

See. 5.08(f)(1) Consent for the release of confidential information must be in writing and signed by the patient, or a parent or legal guardian if the patient is an minor, or a legal guardian if the patient has been adjudicated incompetent to manage his personal affairs, or an attorney ad litem appointed for the patient, as authorized by the *Texas Mental Health Act*, the *Mentally Retarded Persons Act of 1977*, ... Chapter 5, *Texas Probate Code* [guardians of the person or of the estate]; and Chapter II, *Texas Family Code* (suits affecting the parent child relationship); or a personal representative if the patient is deceased, provided that the written consent specifies the following:

- (A) the information or medical records to be covered by the release;
- (B) the reasons or purposes for the release; and
- (C) the person to whom the information is to be released.

Further, the *Communicable Disease Prevention and Control Act* contains the following specific requirements for the release of information relating to tests for AIDS, the Human Immunodeficiency Virus (MV) and antibodies to MV:

See. 9.03. (d) The authorization prescribed by Subsection (c)(2) of this section must be in writing and signed by the person tested or a person legally authorized to consent to the test on the person's behalf and must state the persons or entities or classification of persons or entities to whom the test results may be released disclosed.

The Texas Department of Agriculture Structural Pest Control Service's "Authorization to Release Confidential Information" form was developed to conform to these statutory requirements. For this reason, when you are requested to release information from records under your control, the form must be carefully completed to provide the information required by the statute.

The form may be used to obtain information from other providers and when used for that purpose, it should be completed with the same concern for the statutory, common law and constitutional requirements. Such attention to detail may ultimately save both time and effort.

The *Medical Practice Act*, the *Communicable Disease Prevention and Control Act* and certain other statutes, for instance, those relating to mental health and mental retardation information, provide several other exceptions to the rule of confidentiality relating to medical records. **ANY REQUEST FOR INFORMATION WHICH CANNOT BE ADDRESSED BY THE USE OF THE CONSENT TO RELEASE CONFIDENTIAL INFORMATION FORM MUST BE REFERRED IMMEDIATELY TO THE OFFICE OF GENERAL COUNSEL FOR NECESSARY ACTION.** Because the *Open Records Act* and other statutes give a very limited time period during which Texas state agencies must respond to requests for information, any delay in making these referrals may lead to results which are adverse to the agency.

Please review the release form before releasing information. All the blanks on the form must be filled in, the form must be read by the client and the form must be appropriately signed before the information is released.

**Texas Department of Agriculture Structural Pest Control Service
Authorization to Release Confidential Information**

NAME: _____
(Name of Client)

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

I authorize the following health care provider, attorney, counselor, school, etc.:

(Individual, Medical Doctor, Hospital, Clinic, Attorney, Counselor, School, Etc.)

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

to release the following specific confidential information:

Yes No Developmental Information. Indicate specific information.

Yes No Medical Information. Indicate specific information.

Yes No HIV-Related Information. Indicate specific information.

Yes No Psychological Reports. Indicate specific information.

Yes No Social History. Indicate specific information.

Yes No Other. Indicate specific information.

**to the Texas Department of Agriculture Structural Pest Control Service, P.O. Box 12847, Austin, Texas 78711-2847
Phone 866-918-4481; FAX 888-232-2567; E-mail: spcs@tda.state.tx.us; Web: www.TexasAgriculture.gov/spcs/**

The information released may be used for the following purposes: Enforcement of the Texas Structural Pest Control Act & the Federal Insecticide, Fungicide, and Rodenticide Act.

*******THIS FORM MUST BE SIGNED AND NOTARIZED*******

THIS AUTHORIZATION IS EFFECTIVE UNTIL I REVOKE IT IN WRITING.

This form (____) was read by me (____) was read to me and I understand its meaning. All the blanks were filled in before the form was signed by me.

(Signature) Date _____

(Print/Type Name of Person Authorized to Consent to Release of Information)

(Signature of Authorized Person) (Relationship to Client)

(Address) (Telephone)

The State of Texas
County of _____)

Before me, the undersigned authority, a notary public in and for _____ County, on this day personally appeared _____ known to me to be the person whose name is subscribed to the foregoing authorization to release confidential information to the Structural Pest Control Service of the State of Texas, and who by me being duly sworn, on oath stated that the information given in the said application is true, correct, and complete.

Given under my hand and seal of office this _____ day of _____ A.D. _____
Notary Public in and For _____ County,
Signature _____
Printed Name _____
My Commission Expires _____