



Genesis
Behavioral Health

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Release of Protected Health Information (PHI)

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide Genesis Behavioral Health a written notice.

Patient Name: _____ Date of Birth: ____/____/____

I grant permission for my healthcare provider and their representatives of Genesis Behavioral Health to discuss my care using this disclosure form to share relevant information about my healthcare or discuss financial information for payment on my account.

I authorize the release of my protected health information to the following person(s)/ entity:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

The information you may release subject to this authorization is the following:

Appointment date/time: ____ YES ____ NO Explanation of diagnosis/ treatment plan: ____ YES ____ NO

Lab Reports: ____ YES ____ NO Billing Information: ____ YES ____ NO

____ I do not want any of my information shared.

I authorize the following additional communication methods for Genesis Behavioral Health to communicate information to me about the status of my care:

Email ____ YES ____ NO

Leaving a voicemail regarding lab care ____ YES ____ NO

Mailing Statements/Letters to my Residence ____ YES ____ NO

I understand that my healthcare information at Genesis Behavioral Health is protected. By signing this form, I am granting Genesis Behavioral Health to disclose my protected health information for the purpose of treatment, payment and health care operations.

Genesis Behavioral Health’s Notice of Privacy Practices provides more detailed information about how we may use and disclose this information. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office. If you would Like a copy of our Notice of Privacy Practices, please see the front desk.

Patient/Authorized Representative Signature ____/____/____
Date