TEXAS
Health and Human Services

Form 2277
March 2014-E

Client Information Release

Area Agency on Aging of _____

Individual's Name	Individual's ID

By signing this authorization, you are giving the Area Agency on Aging (AAA) permission to release all or part of your information provided, which includes health information. Failure to provide this authorization will result in limited service by the AAA. This release includes access to a continuum of service(s) available through the AAA or its providers.

Parts A, B and C are to be completed by the individual or personal representative.

I authorize the AAA to release my information to the following person or agency for the purpose(s) stated in Part A. My information will remain available to the person or agency indicated in accordance with the expiration event or date in Part B.

Parts A – Release of Information

I understand that my information may contain protected health information. Release my information to the following person or agency:

☐ Any person or agency necessary to meet my service needs.

☐ Only the persons or entities identified: _____

Check one of the following: ☐ Release all of my information. ☐ Release only the following information:

_____

Parts B – Purpose of Release

☐ General: To assist in assessing, arranging and meeting individual service needs.

☐ Specific: _____

☐ Expiration:

This authorization expires at the point of reassessment, where applicable, or within three years of effective date. _____

Parts C – Signature

_____ Signature – Individual or Personal Representative

_____ Date

☐ Check if you are signing for the individual and describe your authority to act for the individual on the following line:

_____

Note: If the person requesting the release of information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the individual's file.

_____ Signature – Witness

_____ Date

_____ Signature – Witness

_____ Date

Notice to Individual:

- Once the authorization to release your information is granted, the AAA is not responsible for any redisclosure of the information by the recipient.
- You can withdraw permission you have given the AAA to use or disclose health information that identifies you, unless the AAA has already taken action based on your permission. You must withdraw your permission in writing.