

Tarrant County Sheriff's Office
Authorization to Disclose Protected Health Information

The attached form is used to allow an inmate's family, or an authorized person, to verbally receive medical and/or mental health treatment information received during incarceration.

The form needs to be completed and signed by the Inmate and submitted to the Tarrant County Sheriff's Office reception desk. The form will be routed to the appropriate areas for reference when needed; the original will be placed in the Inmate File, and a copy will be sent to JPS, MHMR, Detention Administration, and the Inmate.

A blank hard copy can be requested by asking the Housing Unit Officer or any Tarrant County Sheriff's Office employee.

Please read the form carefully as there are some restrictions and limitations.

Tarrant County Sheriff's Office
Authorization to Disclose Protected Health Information

Date: _____

Inmate Name: _____

Inmate TCSO CID: # _____

I, _____, authorize the John Peter Smith Health Network (JPSHN) and My Health, My Resources (MHMR) to engage in verbal communication or to leave a detailed message with the person authorized below. Communication is related to medical/mental health treatment I have received while in the custody of the Tarrant County Sheriff's Office. The following person is authorized to request and receive information and updates on my medical and mental health treatment.

Authorized Person: _____

Relationship: _____

Phone Number: ____ - ____ - _____

Address: _____

Driver's License or ID Type and Number: _____

This authorization includes **all health information**, excluding (list any exclusions or leave blank if none)

_____ and **expires immediately upon my release or transfer from custody of the Tarrant County Sheriff's Office**. I understand I can withdraw my permission at any time by giving written notice stating my intent to revoke authorization to TCSO and the Authorized Person. Additionally, I understand that this authorization does not include obtaining copies of electronic or medical/mental health records. Further, JPS, MHMR, and the Tarrant County Sheriff's Office reserve the right not to release information if deemed to be a safety and security risk or if determined to be in my best interest. Finally, I understand that treatment will not be denied based on a failure to sign this authorization form.

_____	_____	_____	_____
Inmate's Printed Name	Inmate's Signature	Inmate's TCSO CID	Date

- Original: Inmate File
- Copy: Inmate
- Copy: Detention Administration
- Copy: JPS Medical
- Copy: MHMR