



# TEXAS DEPARTMENT OF INSURANCE

## Compliance Division - Consumer Protection (111-1A)

333 Guadalupe, Austin, Texas 78701 ★ PO Box 149091, Austin, Texas 78714-9091  
(800) 252-3439 | F: (512) 490-1007 | TDI.texas.gov | @TexasTDI

DATE

### Authorization to Disclose Protected Health Information or Other Confidential Information

In order to fully resolve a complaint filed with TDI, TDI may need to disclose your protected health information or other confidential information provided with the complaint. Please read this entire form before signing and complete all the sections that apply to you.

Covered entities, as that term is defined by Texas Health & Safety Code § 181.001, and including TDI, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law.

NAME OF PATIENT OR INDIVIDUAL

OTHER NAMES USED

DATE OF BIRTH

ADDRESS

CITY STATE ZIP CODE

PHONE ALTERNATE PHONE EMAIL ADDRESS (OPTIONAL)

I authorize the following to disclose the individual's protected health information or other confidential information:  
Texas Department of Insurance  
333 Guadalupe  
Austin, TX 78701

### Who can receive and use the health information or other confidential information?

PERSON/ORGANIZATION NAME

ADDRESS

CITY STATE ZIP CODE

PHONE FAX

By signing this form, I also authorize TDI to share the complaint and any attached documents, which may contain my health information or other confidential information, with other state, federal, and international regulatory agencies and law enforcement authorities.

**Reason for disclosure:** Complaint filed with the Texas Department of Insurance.

**What information can TDI disclose?** Complete the following by indicating those items that you want TDI to disclose. A minor patient must sign for the release of some of these items.

All health information      Email address      All other information

**Your signature is required to release the following information:**

- \_\_\_\_\_ Mental health records (excluding psychotherapy notes)
- \_\_\_\_\_ Genetic information (including genetic test results)
- \_\_\_\_\_ Drug, alcohol, or substance abuse records
- \_\_\_\_\_ HIV/AIDS test results/treatment
- \_\_\_\_\_ Motor vehicle records

**Effective time period (optional).** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date:

\_\_\_\_\_  
MONTH DAY YEAR

**Right to revoke:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization or agency named under "Who can receive and use the health information or other confidential information." I understand that withdrawing my permission will not affect prior actions taken in reliance on this authorization by entities that had permission to access my health information or other confidential information.

**Signature authorization:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information or other confidential information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code §181.154(c). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

\_\_\_\_\_  
SIGNATURE OF INDIVIDUAL OR INDIVIDUAL'S LEGALLY AUTHORIZED REPRESENTATIVE DATE

\_\_\_\_\_  
PRINTED NAME OF LEGALLY AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

If representative, specify relationship to the individual:  
Parent of minor                      Guardian                      Other \_\_\_\_\_

A minor individual must sign to authorize the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, for example, Texas Family Code § 32.003).

\_\_\_\_\_  
SIGNATURE OF MINOR INDIVIDUAL DATE

**Access and Correction of Personal Information**

With few exceptions, you are entitled to be informed about the information that the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please email TDI's Legal Services Division at AgencyCounsel@tdi.texas.gov or review TDI's Corrections Procedures ([www.tdi.texas.gov/commish/legal/lccorprc.html](http://www.tdi.texas.gov/commish/legal/lccorprc.html)).