



Housing Authority of the City of Austin

Established in 1937

REVISED 6-26-06

Consent for the Release of Protected Client Health Information

Client Name: _____ Client #: _____

Social Security Number: _____ Date of Birth: _____

I authorize _____ to disclose the specified health care information
(Physician name or health care provider/ agency)
to the Housing Authority of the City of Austin.

Disclosed information limited to:

Disability Status Special Accommodations Needed Estimated length of disability period

Records/ Services Dated From: _____ To: _____

The purpose of this disclosure is to determine eligibility, admissibility, income allowances, and necessary accommodations for the Housing Authority's housing program(s).

Physician/ Medical Practitioner's Name: _____

Address: _____

Fax #: _____ Telephone #: _____

This authorization can be cancelled at any time, in writing, to the above releasing agency, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. The releasing agency cannot control how the protected health information will be used by the agency/ person who receives it under this authorization. The consent, unless revoked, will expire one (1) year from date of signature. You have the right to refuse to sign this authorization. Treatment, payment, or eligibility of benefits will not be conditional upon signing this authorization. You have the right to inspect or copy protected health information to be disclosed. You will receive a copy of the signed authorization.

Applicant Signature: _____ **Date:** _____

For Office Use Only:

To Whom It May Concern:

This person has applied for housing assistance under a program of the U.S. Department of Housing and Urban Development (HUD). HUD requires a PHA to verify all information that is used in determining this person's eligibility, admissibility, income allowances, and necessary accommodations. The applicant has requested that we obtain this information from you. A final determination cannot be made until you have completed the attached two-paged form. Please return the completed form to the address below or fax it to the fax number below. You are not required to have the attached form notarized, but it is preferred.

Staff Signature: _____ Date: _____