Catholic Charities Fort Worth

Subject: Client Rights

Fax: 817.289.3616 Email: hopecenter@ccdofw.org

Applies to: Hope Center

Parish Client Consent to Obtain/Disclose Information Form
(including Protected Health Information)

Form Number: 2500-16
Effective: *2/1/16*
Revision effective: 8/15/17
Reviewed:

COMPLETE ALL SECTIONS, DATE AND SIGN

I. I, _____, give permission to _____
(Name of Client) (Name of Parish or Conference)
to obtain and/or disclose information regarding myself to Catholic Charities, Diocese of Fort Worth, Inc. I also give permission for both of these organizations to obtain and/or disclose information from my record(s) at the organizations identified in Section II.

II. The Information regarding myself can be obtained or disclosed among the following organizations (check all that apply):

☐ TXU Energy
☐ Arlington Water

III. The purpose or need for this disclosure is:

☒ Eligibility determination to verify current charges and confirm Catholic Charities has not yet assisted this year
☒ Client account information

IV. The information to be disclosed from my record:

☒ Billing and payment history
☒ Account and/or resident information
☒ Parish Referral Form and program required paperwork

V. I understand that I may revoke this authorization in writing submitted at any time any time except to the extent that Catholic Charities, Diocese of Fort Worth, Inc. has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to the Hope Center Program Manager, P.O. Box 15610, Fort Worth, TX 76119 , fax 817-535-8779, stating my intent to revoke this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

_____
(Enter if different from one year after date below)

I understand that Catholic Charities will not condition eligibility for services on my providing this authorization except if such services are provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

_____ _____
Signature of Client DATE

_____ _____
Signature of Personal Representative *(State relationship to client) or Witness (if signature is thumbprint or mark)* DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.