TEXAS Health and Human Services

Form H1836-B
June 2025

Medical Release or Physician's Statement

Section 1 – To Be Completed By Staff

Name of Patient	Date of Birth	Social Security No.
Case Name, caregiver	Case No.	Patient's Usual Job
Advisor's Name	BJN	Office Area Code and Fax No.
Office Street Address, City, State and ZIP Code		Office Mail Code

Section 2 – The Physician Completes this Section

The person caring for the patient named above applied for benefits with our agency. Federal and state regulations require that people receiving benefits work or participate in activities to prepare them for work. This is unless they cannot due to a circumstance such as being needed in the home for the patient's disabling illness or injury. This person claims that circumstance. Complete parts A and B below. After you complete the form, you may give it to the person or mail it to HHSC at the address in Section 1.

Part A – Caring For a Disabled Family Member

To what extent can the caregiver work or participate in activities to prepare for work? Mark **one** of the following below.

◯ 1. The caregiver can work, or participate in activities to prepare for work outside or inside of their home, full time

◯ 2. ◯ (a) The caregiver can work or participate in activities to prepare for work outside of their home, part time at _____ hours per week.

◯ (b) The caregiver can work or participate in activities to prepare for work inside of their home, part time at _____ hours per week.

◯ 3. The caregiver cannot work or participate in activities. If you check this box, indicate which of the following applies:

◯ (a) The disability is permanent.

◯ (b) The disability is not permanent and is expected to last more than 6 months.

◯ (c) The disability is not permanent and is expected to last 6 months or less.

Provide more detail, if necessary:

Part B – Diagnosis

Primary Disabling Diagnosis	Secondary Disabling Diagnosis

Comments

Office Street Address or P.O. Box, City, State and ZIP Code			Office Area Code and Phone No.
Typed or Printed Name of Physician	Signature of Physician	Date	License No.

Section 3 – Authorization to Release Medical Information

The patient or patient's personal representative completes this section.

Patient's Name: _____

The applicant is requesting an exemption from participating in the employment services program because they are needed in the home due to your disabling illness or injury. When you sign this authorization, you are giving HHSC permission to contact your doctors, medical facilities, or other health care providers to request copies of your health information as shown below. You must sign this form if you want the applicant to be eligible for an exemption from the employment services program.

I authorize: _____

Doctor, Medical Facilities or other Health Care Providers

to complete Form H1836-B, Medical Release or Physician's Statement, and release the information to HHSC and the Texas Workforce Commission to verify that the applicant is needed in the home due to my disabling illness or injury. They therefore cannot participate fully in the employment services program.

This authorization expires on: _____

_____ _____
Patient or Personal Representative's Signature **Date**

Describe your authority to act for the patient if you are signing for the patient.

Note: If the person requesting the release of case information cannot sign their name, two witnesses to their mark (X) must sign below:

_____ _____
Witness **Date**

_____ _____
Witness **Date**

Notice to Client

HHSC, as receiver of this information, will protect your personal health information per federal and state privacy regulations. If you authorize release of your health information to other parties, it may not be protected by privacy regulations.

You can withdraw permission you have given your doctor or health care provider to use or disclose health information that identifies you, unless they have already acted based on your permission. You must withdraw your permission in writing.