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| ***tree_of_life_by_scaryhoboclown[1]*** |
| ***North Texas Family Services***  ***Lauren Gordon, LCSW*** |

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| Mailing address:  **8301 Lakeview Parkway Suite 111-131, Rowlett TX 75088**  Interview office:  2411 Wesley Street, Suite 303, Greenville, TX | Telephone: 214.675.3978  www.ntxfamilyservices.com |

**Authorization for Use and Release of Information**

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, hereby authorize and request Forensic Counseling Services to disclose to and/or, acting on my behalf, obtain from the above-named person or organization any and all records and information about the above client(s) in the following areas:

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|  **All health information** |  Admission summaries |  Police records |
|  Dental care |  Social histories |  CPS records |
|  School information |  Treatment summaries |  Probation/parole information |
|  Day care information |  Discharge summaries | □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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Your initials are required to release the following information:

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| --- | --- |
| \_\_\_ Mental health records (excluding psychotherapy notes as defined by CFR 164.501) | |
| \_\_\_ Drug, alcohol, or substance abuse records (including those covered under 42 CFR part 2) | |
| \_\_\_ HIV/AIDS test results/treatment | \_\_\_ Genetic information (including test results) |
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The purpose of this disclosure of information is at the request of the individual. Dates of service include the entire lifetimes(s) of the above-named persons(s). This release is effective until completion of services unless otherwise revoked. A copy or fax of this authorization is as valid as the original. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this form.

**The person signing this form will be responsible for any fees incurred from this request.**

I understand information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by HIPAA privacy regulations. I consent to redisclosure of any information protected by 42 CFR part 2. I acknowledge that this authorization may be revoked via written notice at any time by sending written notification to Forensic Counseling Services at the above address. I understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. I acknowledge I have read this form, agree to the uses and disclosures of the information described, and was offered a copy of this authorization for my records.

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Printed Name Relationship to client(s) Signature Date