

HELEN FARABEE REGIONAL MHMR CENTERS
AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

(Use Black Ink Only)

Client Name: _____ Case#: _____ SS #: _____ DOB: _____

I Hereby Authorize: Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact Person: _____ Phone #: _____

To Release to: Name: _____
Address: _____

To Obtain From: City: _____ State: _____ Zip: _____
Contact Person: _____ Phone #: _____

Information to be Released: (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Client ID (Phone, Address) | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Assessment/Social History | <input type="checkbox"/> Psychological Evaluation/DMR | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Treatment Plan/Review /PDP | <input type="checkbox"/> Physicians Orders | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Verbal Exchange | <input type="checkbox"/> Physicians Notes | |
| <input type="checkbox"/> Other: _____ | | |

This release is for the following reason(s) (be specific): _____

NOTE: The above information may include drug and alcohol/mental health/communicable disease information, including HIV test results, AIDS related information. Also, records can be released to other components of the TXMHMR system. I have been informed that this specific release is required because if my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records; 42 CFR, Part 2, the records cannot be disclosed without my written consent unless otherwise provided for in the regulations. A general authorization for the release of medical or other information is **not** sufficient for this purpose. If I am signing as a parent of a minor child or guardian of a minor child, I further understand the information released may contain references to my family or myself. Except for information related to alcohol or drug abuse treatment, the information disclosed pursuant to this authorization may not be protected by medical privacy laws and may be subject to re-disclosure by the recipient. The authorizing person through written notice may revoke this authorization at any time, except to the extent that the Center has already relied upon you authorization to use or disclose your health information as described in the Notice of Privacy Practices. We will not withhold treatment, Medicaid benefits, or payment processing if you refuse to sign the authorization. If not earlier revoked, this consent shall expire on:

_____ or Not to exceed **One (1) year from date of client signature.**

Date or Event

This authorization is hereby Revoked at my request:

Form must be completed before signing

Client Signature Date

Client Signature Date

Legal Authorized Representative Date
And Relationship to Client

Legal Authorized Representative Date

Witness Date

Witness Date

_____ Action by Clinical Records
_____ File in Chart