Helen Farabee Centers

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

INDIVIDUAL'S NAME: _____ CASE#: _____ SS#: _____ DOB: _____

I Hereby Authorize: **Helen Farabee Centers**
516 Denver
Wichita Falls, Tx 76301

Medical Records
Fax # 940-696-6248

☐ **To Release to:**
☐ **To Obtain From:**

Name/Facility: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____ Fax#: _____

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

☐ Continuity of Care
☐ To discuss with my family the care and treatment I receive
☐ At my request

Information to be Released: (Check all that apply) **Date Range: _____**

Mental Health

☐ All Records
☐ Psychiatric Evaluation
☐ Physician Notes/Orders
☐ Discharge Summary
☐ Lab Reports
☐ Caseworker Notes/ANSA/CANS
☐ Verbal Exchange
☐ Other _____

IDD

☐ All Records
☐ Recovery Plan
☐ Safety Plan
☐ Treatment Plan
☐ Behavior Support Plan
☐ Psychiatric Evaluation
☐ Intervention Progress Notes
☐ School/ISD
☐ Admission Review Dismissal
☐ Psychological Evaluation/DID
☐ Labs/Physician Orders
☐ Assessments
☐ Full Individual Evaluation
☐ Progress Notes (CW/Physician)
☐ Nursing Observation Notes
☐ Discharge Information/Furlough Referral
☐ Daily Functioning Checklist
☐ ICAP/Testing/Summary
☐ Verbal Exchange
☐ Other _____

NOTE: Depending on consent, the above information may include drug and alcohol/mental health/communicable disease information, including HIV test results, and/or AIDS related information. While general psychiatric and/or medical information may be released to other components of Health and Human Services, records related to HIV/AIDS and/or alcohol/drug abuse treatment cannot be disclosed without additional consent specific to that content as noted above (Code of Federal Regulations Title 42, Chapter I, Sub A, Part 2). If signing as a parent of a minor child or guardian of an individual, note that the information released may contain references to family (except for information related to alcohol or drug abuse treatment). The authorizing person through written notice may revoke this authorization at any time, except to the extent that the Center has already relied upon authorization to use or disclose health information as described in the Notice of Privacy Practices. If not earlier revoked, this consent SHALL EXPIRE ONE (1) YEAR FROM THE DATE OF THE INDIVIDUAL'S SIGNATURE.

_____ ***(Initials) I do authorize the disclosure of HIV/AIDS or Alcohol and Substance Abuse Treatment.*** ***(Failure to initial in the provided space will result in redaction of records.)***

Form must be completed before signing:

_____
Individual's signature **Date**

_____
Legal Authorized Representative **Date**

_____
Witness **Date**

This authorization is hereby revoked at my request:

_____
Individual's signature **Date**

_____
Legal Authorized Representative **Date**

_____
Witness **Date**

_____ Action by Medical Records-records will be sent upon receipt of consent
_____ File in Chart only, no other action required at this time by medical records

_____ # OF PAGES RELEASED