Helen Farabee Centers

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Please Print Legibly – This is a Legal Document

INDIVIDUAL'S NAME:_____ DOB:_____ Last 4 of SS#:_____ CASE#:_____

I Hereby Authorize:

Helen Farabee Centers
516 Denver
Wichita Falls, Tx 76301

Medical Records
Fax #940-696-6248
Email: Medicalrecords@helenfarabee.org

☐ **To Release to:**

☐ **To Obtain From:**

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

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

☐ Parent ☐ Step-Parent ☐ Attorney
☐ Sibling ☐ Grandparent ☐ Other _____

Information to be Released: (Check all that apply): ___Past 6 months ___Past Year ___Past 2 years ___Entire Record

MentalHealth

☐ 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
☐ Special Ed/ISD
☐ Admission Review Dismissal
☐ Psychological Evaluation/DID
☐ Labs/Physician Orders
☐ Full Individual Evaluation
☐ Progress Notes (CW/Physician)
☐ Nursing Observation Notes
☐ Transcript
☐ Discharge Information/ Furlough Referral
☐ Daily Functioning Checklist
☐ ICAP/Testing/Summary/Assessments
☐ Verbal Exchange
☐ Other _____

_____ (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** **Witness** **Date**

_____
Legal Authorized Representative **Date**

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

FOR OFFICE USE ONLY: **This Authorization is hereby revoked at my request:**

_____ _____
Individual's Signature **Date** **Witness** **Date**

_____
Legal Authorized Representative 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