Helen Farabee CENTERS
— a commitment to caring —

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Office Use Only
Client ID #

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

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 (individual or family member) / Specific Practitioner/ Facility: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone: _____ Fax: _____
Action required by Medical Records: ___ No action required (file only): __

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

- ☐ Parent
- ☐ Grandparent
- ☐ Step-parent
- ☐ Sibling
- ☐ Attorney
- ☐ Doctor
- ☐ Relative
- ☐ Friend
- ☐ Other _____

Mental Health/IDD to be Released: (Check all that apply): _____Past 6 months ____Past Year ____Past 2 years _____All Records

- ☐ Verbal Exchange
- ☐ Psychiatric Evaluation
- ☐ Physician Notes/Orders
- ☐ Lab Reports
- ☐ Case Worker Notes/ANSA/CANS
- ☐ Recovery Plan
- ☐ Safety Plan
- ☐ Treatment Plan
- ☐ Special Ed/Testing
- ☐ Discharge Summary
- ☐ Behavioral Support Plan
- ☐ Intervention Progress Notes
- ☐ Admission Review Dismissal
- ☐ Psychological Evaluation/DID
- ☐ Discharge Information/ Furlough Referral
- ☐ Full Individual Evaluation
- ☐ Nursing Observation Notes
- ☐ Transcript
- ☐ Daily Functioning Check List
- ☐ ICAP/Testing/Summary/ Assessments
- ☐ Other

Form must be completed before signing:

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

_____
Legal Authorized Representative Date

_____ (Initials) I do not authorize the Disclosure of HIV/AIDS or Alcohol and Substance Abuse Treatment

____ # of pages