



**DePelchin
Children's Center**

And AFFILIATED ORGANIZATIONS

**Authorization for: _____ Use and Disclosure _____ Inspection _____ Amendment
Of Protected Health /Client Information**

I _____ of _____ authorize
(Parent/Guardian/Conservator) (Client) (Date of Birth)
DePelchin Children's Center, whose main office address is 4950 Memorial Dr., Houston, TX,
77007 to disclose protected health /client information from the client record(s) of _____
(client name)
to _____
(Name/Address of person/organization to which disclosure is to be made)

(Relation to the client)
Fax # _____ Phone # _____
For service dates: _____
(Specify dates of service)

The protected health/client information to be disclosed includes the following:
____ Discharge/Transfer Summary ____ Psychosocial ____ Psychological ____ Psychiatric
____ Initial Assessment ____ School Reports ____ Physician Notes ____ Unrestricted
____ Medication Records ____ Treatment Plans ____ Other: _____

For the purpose of (circle one): Continued Care; Education; Legal; Insurance; Other: _____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and in any event this authorization shall expire 90 days after date of signature (authorization to provide information to a contracted or cooperating service provider for ongoing service provision will expire after one year) unless another date is specified. Specification of date, event, or condition upon which this consent expires: _____

*** I acknowledge that this authorization is voluntary.**

***Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.**

***Information disclosed as a result of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.**

_____ I acknowledge, and authorize that released information may contain alcohol, drug abuse, HIV testing
(Initials) and results, or AIDS information.

TO PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose FOR CLIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2 I, the undersigned, also understand that a copy of this signed authorization form is as acceptable as the original.

Parent/Guardian/Conservator Relationship to Client Date

Client (18 years or older) Date

Witness (Must be 18 or older) Date

***Fees/charges that comply with all laws and regulations applicable to release of Protected Health/Client Information may be obtained as a result of the disclosure. Payment is due at time of release.**