DePelchin
CHILDREN'S CENTER

Authorization to Release:

☐ Use and Disclosure ☐ Review of Record ☐ Amendment of Protected Health/Client Information

I _____of _____, (_____) authorize
Parent/Guardian/Conservator Client Date of Birth

The Records Management Dept., Service Provider or Supervisor of listed client, or Designated Administrative Assistant of DePelchin Children's Center, whose main office address if 4950 Memorial Dr., Houston, TX 77007, to disclose or obtain protected health/client information from the client record(s) of _____
Client Name

to/from: _____ _____
Name, Address of person/organization to which disclosure is to be made or received from Relation to client

Fax #: _____ Phone #: _____

For service dates: _____
Specify Dates of Service

The protected health/client information to be disclosed includes the following:

☐ Session Notes of Counselor/Psychiatrist
☐ Discharge/Transfer Summary
☐ initial Assessment/Evaluation
☐ Treatment Plans
☐ Psychological Evaluation
☐ Medication Records
☐ Home Study
☐ Daily Log/Case Notes (non-counseling)
☐ School Reports
☐ Appointments Dates Only
☐ Verbal Only
☐ Unrestricted (All)
☐ Other: _____

For the purpose of: ☐ Continued Care ☐ Education ☐ Legal ☐ Insurance ☐ Other:_____

I understand that I may cancel this authorization in writing that is signed and dated to the Privacy Officer at any time unless information has already been released due to it or the disclosure is required for payment to the organization. In any event, this authorization shall expire 180 days after date of signature (authorization to provide information to a contracted or coordinating service provider for ongoing service will expire after one year) unless I list another date. List 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 also acknowledge and authorize the release of information regarding HIV or ADIS testing and test results, drug and alcohol if this information has been submitted to DePelchin.

TO PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentially 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 years 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.*