clearhope
counseling & wellness

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH AND OTHER PERSONAL HEALTH INFORMATION

I, _____ hereby authorize _____
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to exchange/release any and all records or information regarding _____
(Name of Patient)

The following items must be **checked** to be included in the use and/or disclosure of other health information:

- ☐ Diagnosis/Treatment Plan
- ☐ Mental health information
- ☐ Psychotherapy notes
- ☐ Drug/alcohol diagnosis, treatment/referral

to _____
(receiving Agency/person) (Address)

Phone Number_____ Fax Number_____Email Address:_____

for the purpose of (please check all that apply):

☐ Continuing (health and mental health) treatment or care and continuity of care	☐ Therapists transition	☐ Billing, payment and financial matters/ arrangements
☐ Consultation, advice, and representation	☐ Housing or other arrangement and services	☐ Other

This consent is valid until (calendar date)_____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

_____ _____
(Minor recipient) (Signature of adult patient or parent)

_____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

_____ _____
(Authorized agent - Power of attorney attached) (Date)

- A charge of $1 per page may be assessed for COPIES of mental health records. This fee is not to exceed $25.
- Records may take 5-15 business days to produce and copy. For additional information regarding rights and responsibilities, please visit: https://statutes.capitol.texas.gov/Docs/HS/htm/HS.611.htmHEALTH AND SAFETY CODE/TITLE 7. MENTAL HEALTH AND INTELLECTUAL DISABILITY/CHAPTER 611/MENTAL HEALTH RECORDS