HELEN FARABEE CENTERS
AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION
(Use Black Ink Only)

Client Name: _____ Case#: _____ SS #: _____ DOB: _____

I Hereby Authorize:
Name: **Helen Farabee Centers**
Address: 516 Denver
City: Wichita Falls State: TX Zip: 76301-
Contact Person: _____ Phone #: _____

☐ **To Release to:**
☐ **To Obtain From**:
Name: _____
Address: _____
City: _____ State: ___ Zip: _____
Contact Person: _____ Phone #: _____

Information to be Released: (check all that apply):

☐ Client ID (Phone, Address)
☐ Assessment/Social History
☐ Treatment Plan/Review /PDP
☐ Verbal Exchange
☐ Psychiatric Evaluation
☐ Psychological Evaluation/DMR
☐ Physicians Orders
☐ Physicians Notes
☐ Progress Notes
☐ Discharge Summary
☐ Lab Reports
☐ Other_____

I (Initials) _____ **DO / _____ DO NOT authorize the disclosure of** ☐ HIV/AIDS.

I (Initials) _____ **DO / _____ DO NOT authorize the disclosure of** ☐ alcohol and drug abuse treatment

This release is for the following reason(s) (be specific):
☐ Continuity of Care ☐ educational placement ☐ at my request
☐ to discuss with my family the care and treatment I receive
☐ assist in additional funding
☐ Other: _____

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 information disclosed pursuant to this authorization may not be protected by medical privacy laws and may be subject to re-disclosure by the recipient. 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. This agency will not withhold treatment, Medicaid benefits, or payment processing based on refusal to sign the authorization. If not earlier revoked, this consent shall expire on:

_____ or Not **to exceed One (1) year from date of client signature.**
Date or Event

Form must be completed before signing

This authorization is hereby revoked at my request:

Client Signature	Date	Client Signature	Date
Legal Authorized Representative	Date	Legal Authorized Representative	Date
Witness	Date	Witness	Date

_____ Action by Medical Records—records will be sent or obtained upon receipt of consent.

_____ File in Chart only, no other action required at this time by medical records.