CHILD & FAMILY
GUIDANCE CENTER OF TEXOMA
Where help, hope and healing begin

Request/Authorization to Release Confidential Records and Information

I, _____hereby authorize Child and Family Guidance Center of Texoma to obtain information from or disclose information to:

Name: _____ Phone: _____

Address:_____ City: _____ State: _____ Zip: _____

Fax: _____ Relationship to Client: _____

Regarding records/information on _____,
DOB _____ , for the following purpose(s):

☐ Further evaluation, treatment, or care ☐ Litigation/legal purposes ☐ Disability Determination

☐ Treatment planning ☐ Research ☐ Case Consultation/Review ☐ Educational

☐ Other: _____

Description of Information to be Disclosed
(Client/Parent should initial each item to be disclosed. Only designated information will be disclosed).

_____ Intake Assessment/Evaluations

_____ Developmental and/or psychosocial history

_____ Discharge/Transfer Summary

_____ Diagnosis/Diagnoses

_____ Treatment Plan or Summary

_____ Presence/Participation in Treatment

_____ Progress in Treatment

_____ Other_____

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

RIGHT TO REVOKE: This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the patient. I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire within 1 year from the date I signed it.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities (referring physicians, other clinical staff/treatment team members at Child and Family Guidance, and other medical/mental health professionals referred to me by CFGC) as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

FEES FOR COPIES: Federal and state laws (TAC § 165.2) permit a fee to be charged for the copying of patient records. If a fee is required, you will be required to pre-pay for the copies before records are released. Records will be furnished by CFGC within 15 business days after the date of receipt by written request for active clients, and within 30 business days for inactive clients.

_____	_____	_____	_____
Signature of client/parent/guardian/representative	Printed name	Relationship	Date

Phone: 903-893-7768 • Fax: 903-893-4979 • Email: intake@cfgcenter.org
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