Between Two Homes®, LLC
www.childreninthemiddle.com
Office (800) 239-3971
Fax (972) 704-2912
brad@childreninthemiddle.com

INSTRUCTIONS FOR COMPLETING THE MENTAL HEALTH PROFESSIONAL AUTHORIZATION FOR USE AND RELEASE OF INFORMATION

1. Complete a separate release for each mental health professional listed on your personal data form.
2. After "To;" fill in the full name of the mental health professional including the professional's professional initials.
3. After "Client(s):" fill in the first line with your name (even if your child was the client) and if the mental health professional saw your child, write in their name below yours on the lines provided. After each name fill in the following line with the individual's date of birth.
4. Initial each line under "Your initials are required to release the following information.
5. On the bottom line, sign your name, print your name, your relationship to the client (either "self", and "father" or "mother") then put the date you signed it.

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Authorization for Use and Release of Information

To: _____

Client(s): _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

I, the undersigned, hereby authorize and request Bradley S. Craig, LMSW-IPR, CFLE and the PF communication coach of Between Two Homes®, LLC to disclose to and/or, acting on my behalf, and as a personal representative under 45 CFR l 64.502(g) regarding records, obtain from the above-named person or organization any and all records and information about the above client(s) in the following areas:

☑ all health information ☑ discharge summaries ☑ counseling/therapy notes ☑ admissions summaries
☑ psychiatric/mental health records ☑ social histories ☑ CPS records ☑ school records
☑ psychotherapy notes ☑ psychological evaluations ☑ treatment summaries ☑discharge summaries
☑ custody evaluations ☑ parenting facilitation records ☑ communication records

Your initials are required to release the following information:
____ Mental health records (excluding psychotherapy notes as defined by CFR 164.50 I)
____ Drug, alcohol, or substance abuse records (including those covered under 42 CFR part 2)
____ HIV/AIDS test results/treatment ___Genetic information (including test results)

The purpose of this disclosure of information is at the request of the individual. Dates of service include the entire lifetimes(s) of the above-named persons(s). This release is effective until completion of services unless otherwise revoked. A copy or fax of this authorization is as valid as the original. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this form.

The person signing this form will be responsible for any fees incurred for this request.

I understand information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by HIPAA privacy regulations. I consent to redisclosure of any information protected by 42 CFR part 2. I acknowledge that this authorization may be revoked via written notice at any time by sending written notification to Bradley S. Craig, LMSW-IPR at the above address. I understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. I acknowledge I have read this form, agree to the uses and disclosures of the information described, and was offered a copy of this authorization for my records.

_____

Signature Printed Name Relationship to client(s) Date