

# Forever More

Adoptions and Custody Evaluations

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## CONSENT FOR RELEASE OF INFORMATION

I, the undersigned, hereby give my permission for \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

to release any records concerning me, \_\_\_\_\_, or my  
children, \_\_\_\_\_ and

to consult with Crystal Baird Ph.D., LPC-S, concerning the court ordered investigation in

Cause Number \_\_\_\_\_. I understand this request for records

and consultation includes my consent for release of information that could otherwise be considered  
confidential, and includes but is not limited to information concerning alcohol or chemical abuse  
and dependency (including illegal drug use), STD's, HIV testing, AIDS, psychiatric illnesses, any  
testing on me or my children, medical records, criminal records, counseling records, child abuse  
investigations, and school records.

This information may be released to:

\_\_\_\_\_  
Crystal Baird Ph.D., LPC

This consent is subject to revocation or withdrawal at any time in the form of written notice to the  
records provider and will expire one year from the date it was signed. Withdrawal of consent does  
not affect any information disclosed prior to the written notice of the withdrawal.

A PHOTOCOPY OF THIS CONSENT IS AS VALID AS THE ORIGINAL.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION**  
**(In Conformance with HIPAA Federal "Privacy Rule" Regulations)**

To: Physician, Provider or Facility Name; 45 CFR §164.508(c)(1)(ii):

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**Name of person/entity to whom the records shall be released;** 45 CFR §164.508(c)(1)(iii):

From: **Forever More Adoptions and Custody Evaluations L.L.C**  
**4880 Boat Club Rd. Ste. 110**  
**Fort Worth, TX 76135**

Evaluators Name: **Crystal Baird Ph.D., LPC-S**

Phone Number: **628-255-5002**

Patient's name \_\_\_\_\_

Social Security No. \_\_\_\_\_

Date of birth \_\_\_\_\_

Date(s) of service Birth-Present

I, the undersigned, authorize release of information specified below from the medical record(s) of the above-named patient.

**The patient information is needed for legal purposes.** 45 CFR §164.508(c)(1)(iv)

**Description of records/information to be released (check all that apply);** 45 CFR §164.508(c)(1)(i):

- |   |   |
|---|---|
| <input type="checkbox"/> All in-patient dictation and diagnostic reports for date(s) of service | <input type="checkbox"/> Progress notes                                       |
| <input type="checkbox"/> Emergency room notes and diagnostic reports                            | <input type="checkbox"/> Case notes   |
| <input type="checkbox"/> History and physical   | <input type="checkbox"/> Intake/history                                       |
| <input type="checkbox"/> EKG  | <input type="checkbox"/> Diagnosis  |
| <input type="checkbox"/> Medication records   | <input type="checkbox"/> Results or summary of testing                        |
| <input type="checkbox"/> Discharge summary  |   |
| <input type="checkbox"/> Lab/pathology reports  | <input checked="" type="checkbox"/> other (please specify) <u>All Records</u> |
| <input type="checkbox"/> PFT  |   |
| <input type="checkbox"/> Operative report   | <u>including psychiatric/psychological/counseling</u>                         |
| <input type="checkbox"/> Radiology  | _____   |
| <input type="checkbox"/> Holter monitor   | _____   |
| <input type="checkbox"/> Consultation notes and reports   | _____   |
| <input type="checkbox"/> Echo   |   |
| <input type="checkbox"/> Orders   |   |
| <input type="checkbox"/> Face sheet   |   |
| <input type="checkbox"/> Dental records, notes  |   |

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). 45 CFR §164.508(c)(2)(iii).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law. 45 CFR §164.508(c)(2)(i); 45 CFR §164.508(c)(2)(ii):

This authorization will expire One Hundred Eighty (180) days from the date of my signature below, unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: \_\_\_\_\_. 45 CFR §164.508(c)(1)(v)

Date of signature: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient or legally authorized representative; 45 CFR §164.508(c)(1)(vi):

Printed name: \_\_\_\_\_

## **Forever More**

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682-255-5002

### **CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

Note: This form release is to allow the attorneys to have access to the custody evaluation without the expense of a subpoena.

I, \_\_\_\_\_, give my permission for Crystal Baird Ph.D., LPC-S to release any and all confidential information, contained in the custody evaluation process, adoption process or any other court proceeding, concerning me or my minor child/children, to any attorney of record in Cause No. \_\_\_\_\_, including my attorney, the opposing attorney, the amicus attorney, ad litem attorney and to any party representing him/herself without an attorney. I understand that this consent for release includes social study personal data provided by me, interview notes and any other records or documents obtained by Dr. Baird that are not otherwise restricted or protected from release by law.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_