Forever More

Adoptions and Custody Evaluations

Crystal Baird MS., LPC
1201 East Belknap St.
Fort Worth, Texas 76102
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512-963-4333

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 MS., LPC, 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 MS., 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 CRF §164.508(c)(1)(ii):

_____ Telephone:_____

Address: _____

_____

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

From: **Forever More Adoptions and Custody Evaluations L.L.C**
1201 East Belknap St.
Fort Worth, Texas 76102

Evaluators Name**: Crystal Baird MS., LPC**
Cell Phone Number: **512-963-4333**

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 CRF §164.508(c)(1)(iv)

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

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

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 CRF §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 CRF §164.508(c)(2)(i); 45 CRF §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 CRF §164.508(c)(1)(v)

✓ Date of signature:_____ ✓Signature:_____
Patient or legally authorized representative; 45 CRF §164.508(c)(1)(vi)**:**

✓Printed name: _____
Relationship to patient; 45 CRF §164.508(c)(1)(iv): Self/Parent

✓Address:_____

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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 MS., LPC to release any and all confidential information, contained in the custody evaluation process, 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 Crystal Baird MS., LPC that are not otherwise restricted or protected from release by law.

✓Signature: _____

✓Printed Name: _____

✓Date:_____