COUNSELING CENTER OF NORTH TEXAS

303 S. Highway 78 Suite 100 Wylie, TX 75098
720 E. Park Blvd. Suite 204 Plano, TX 75094
Phone: 469-342-3468 Fax: 469-342-3466

Authorization to Use or Disclose Health Information

Client Name: _____ Date of Birth: _____

Social Security No.: ___-___-___ Client Address: _____

I authorize release of the following health information:

- ✓ Any and all written and/or verbal medical and/or mental health records/information
- ✓ Any and all written and/or verbal medical and/or mental health billing records

I authorize the following highly confidential information to be disclosed:

- ✓ Information regarding mental health
- ✓ Psychosocial History
- ✓ Progress/Psychotherapy notes
- ✓ Psychological Testing/Evaluation
- ✓ Information regarding sexually transmitted disease
- ✓ Information regarding sexual assault
- ✓ Information regarding HIV/AIDS and testing
- ✓ Psychiatric treatment and medical records
- ✓ Information regarding alcohol or drug abuse treatment
- ✓ Information regarding child abuse and/or neglect

Restrictions or limitations on information to be released (specify): _____

_____

I authorize disclosure of the above listed information to the following individual or organization:

Name: _____
Address: _____
Telephone: _____

If I am signing as a parent or guardian of a minor, I understand that the records released may contain references to my family and myself. I understand that this consent form gives the Counseling Center of North Texas permission to share confidential information about me and/or my child in the ways described above.

- I understand that I have a right to revoke the authorization, in writing, at any time. I understand that a cancellation will not apply to information that has already been released under this authorization. Unless I cancel it sooner, this authorization will expire on the following date, event or condition: _____.
  If I fail to specify an expiration date, event or condition, this authorization will expire in one year from the date appearing at the bottom.
- I understand that I am financially responsible for costs involved in this request as outlined in my signed Inform and Consent with Counseling Center of North Texas. I understand that if a subpoena is issued for court appearance I am required to provide CCNT a financial retainer before the date of the court appearance.
- To the party receiving this information: if the records disclosed to you pursuant to this authorization contain information related to alcohol and/or drug abuse, HIV/AIDS related information, confidential communicable disease information, and/or psychiatric mental health information, the information has been disclosed to you from records protected by federal confidentiality rules (42C.F.R. Part 2) or by Texas law, the Federal and state rules prohibit you from making any further disclosure of such information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- I understand matters discussed on this form. I release the provider, officers and directors, staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
- A copy of this executed release serves the same purpose as an original.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of for which the authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed, as provided by federal government's rules, which are in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that healthcare cannot be conditioned on this authorization.

_____ _____.

Client/Legal Representative Signature Date