INDEX = 0100

ANDREWS CENTER
AUTHORIZATION FOR RELEASE/OBTAINING OF INFORMATION

I,

Name	**DOB**	**SSN#**	**Case#**

Authorize:	To disclose to:

INFORMATION RELEASED WILL BE: ☐DOCUMENTED ☐VERBAL

The following information from my records:

- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ D&E Packet
- ☐ Initial Assessment/Social History
- ☐ Other – Specify _____
- ☐ Medications prescribed
- ☐ Discharge/Transfer Summary
- ☐ Recent Lab Work
- ☐ Psychiatric/Medical History
- ☐ HIV/AIDS

The purpose or need for such disclosure is: _____

I give permission to release copies of the record described above, I understand that the specific type of information to be disclosed may include drug, alcohol, or mental health. I understand I may revoke or cancel this authorization at any time, with the exception that action has already been taken. This authorization will remain in effect for 180 days or the time period specified below, in order to carry out the purpose for which permission was given. I understand that the program releasing these records is free from all legal liabilities that may arise from the act. I understand that I have the right to limit the information that is to be released and who can see the information.

I REQUEST THE FOLLOWING LIMITATIONS:_____

This authorization will expire on:_____

_____ _____
SIGNATURE OF INDIVIDUAL RECEIVING SERVICES DATE

_____ _____
SIGNATURE OF PARENT/LEGAL REPRESENTATIVE DATE

_____ _____
WITNESS DATE

REVOCATION OF CONSENT
(Do not complete until Revoke for Consent has been requested)

I, _____, hereby revoke or cancel this authorization effective_____(date).

_____ _____
Client/Parent/Legal Representative Signature *Date*

_____ _____
Witness *Date*

NOTICE TO RECEPIENT OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42.CFR pat 2) prohibit you or your organization from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization or 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 client/patient.
MENTAL HEALTH: This information is released subject to the "Confidentiality" provisions of TX.H.S. Code 611 and Texas Rules of Evidence (Civil Criminal) Rules 510.
DRUG/ALCOHOL: This information is released subject to the "Confidentiality" provisions of 42 U.S.C. 290dd-2:42 C.F.R.> Part 2.
HIV/AIDS: This information is released subject to the "Confidentiality" provisions of the Communicable Disease Prevention Control Act of 1987, and as amended. TX.H.S. Code 81.001: the Human Immunodeficiency Virus Services Act. TX.H.S. Code CH 85.001.

Date Released_____ Person Releasing Information_____

A PHOTOCOPY OR FACSIMILE IS AS VALID AS THE ORIGINAL.