Family Houston Houston, Texas

AUTHORIZATION FOR DISCLOSURE OF CLIENT RECORD INFORMATION

Client Name:_____ Client ID #:_____

DOB:_____ S.S.#:_____

I hereby authorize and request:	**To provide to:**
Family Houston	
Name	Name
PO Box 70068	
Address	Address
Houston, TX 77270	
City/State/Zip	City/State/Zip
713-861-4849	
Phone	Phone

Confidential information concerning the above named individual: I understand that such disclosure will be made for the following purpose(s) (Check one):

- ☐ Follow-up
- ☐ Monitor medical status
- ☐ Facilitate transfer
- ☐ Coordinate care
- ☐ Provide documentation of prior treatment
- ☐ Coordinate Discharge Planning
- ☐ Primary Care Provider Coordination
- ☐ Legal proceedings
- ☐ Confirm treatment participation and acceptance of treatment recommendations.
- ☐ For billing purposes

Other (Specify): _____

And the disclosure shall be limited to the following specific types of information (check one):

- ☐ All records related to the treatment of the above-named person.
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Letter or verbal summary of counselor's assessment, treatment, and recommendations for the above-named person.
- ☐ Information required for billing purposes (diagnosis and dates of service)

Copies of this information may include the diagnosis/treatment of drug and alcohol abuse, Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), or psychiatric disorders**.** I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I further understand that I am not required to sign this authorization form in exchange for receiving services from Family Services of Greater Houston. **I understand that this consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance on it. In any event, this consent shall expire one (1) year from the date signed unless revoked earlier. Expiration Date**: _____

Client Signature:_____ Date:_____

If I am signing as parent of a minor child, I further understand that the information released may contain references to myself and family.

Legal Representative's Signature:_____ Date:_____

Relationship:_____

Witness' Signature:_____ Date:_____

I hereby revoke this consent.
Client/legal representative's signature:_____ Date:_____

Staff's Signature/Title:_____ Date:_____

Staff Name (please print):_____