THE WOODLANDS BEHAVIORAL HEALTH & WELLNESS CENTER

Authorization for Release of Information

PLEASE COMPLETE SEPARATE RELEASES FOR ADDITIONAL PARTIES
(I.E. SCHOOLS, PHYSICIAN'S OFFICES, FAMILY MEMBERS. ETC.)

Client Name_____ **DOB**_____

I hereby authorize the following person/facility to **receive / release** (circle one or both) information relating to me/my child's medical, educational, and mental health history with The Woodlands Behavioral Health & Wellness Center:

Name of Person:_____

Company/School:_____

Relation:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

For the following purpose *(Please check one)*: ☐ Mental/Medical Care ☐ Legal ☐ Other (specify below)

Please specify what information you authorize our clinic and/or requesting parties to be released:

◯ Specific Dates:_____ to _____ ◯ All Dates

☐ Entire Record	☐ Mental Status Exam	☐ School Meeting Information
☐ Admissions Notes	☐ Progress Notes	☐ School/Work Accommodations
☐ Medication Records	☐ MD Orders	☐ Rating Scales
☐ Discharge Summary	☐ School Reports/Testing	☐ Treatment Plans
☐ Psychological/Diagnostic Testing	☐ Verbal ONLY	☐ Financial Information
☐ Scheduling	☐ Emergency Contact	☐ Other:_____

You have the right to revoke this authorization in writing at any time by sending written notification. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorizing may be subject to re-disclosure by the recipient of your information and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule.

_____ _____ _____

Printed name of Client/Guardian | Signature of Client/Guardian | Date

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