RELEASE OF INFORMATION AUTHORIZATION FORM

I, _____, whose date of birth is _____authorize Danny L. Ross, M.Ed., CSC, LPC to disclose to and/or obtain information from _____

Whose address is _____
Phone number: _____
Fax number: _____

The following information in regard to:
_____.

Description of Information to be disclosed:

☐ Assessment
☐ Testing Information
☐ Diagnosis
☐ Educational Information
☐ Psychosocial Evaluation
☐ Presence/Participation in Treatment
☐ Mental Health Evaluation
☐ Continuing Care Plan
☐ Treatment Plan or Summary
☐ Progress in Treatment
☐ Current Treatment Update
☐ Other _____

In addition, I authorize that this will include health information relating to (check if applicable):
☐ HIV/AIDS Test Results/Treatment
☐ Drug, Alcohol or Substance Abuse Records (Including those covered under 42 CFR part

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:
_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Danny L. Ross, M.Ed., CSC, LPC at the above address. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Effective Time Period/Expiration
This authorization is valid until the earliest of following: the occurrence of death of the individual; the individual reaches the age of maturity; permission is revoked in writing; 365 days from the date of signing; or the following specific date:

Month_____Day_____Year_____

Conditions
I further understand that Danny L. Ross, M.Ed., CSC, LPC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: could potentially impact your therapeutic process and treatment plan. Other _____.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Disclosure
I understand that there is the potential that the recipient and that may disclose the protected health information that is disclosed pursuant to this authorization federal or state privacy laws may no longer protect the protected health information.

Signature Authorization
I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health and Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). Upon request, I will be given a copy of this authorization for my records.

_____
Printed Name

_____
Signature of Client Date

_____
Signature of Parent(s), Guardian or Legally Authorized Representative Date

If you are signing as representative, specify relationship to client:
□ Parent(s) of Minor
□ Guardian
□ Other_____

A minor individual's signature is required for the release of certain types of information, including, for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse and mental health treatment.

_____

Printed Name

_____

Signature of Minor Client Date