CONSENT FOR RELEASE OF INFORMATION

Client Name _____ Maiden/Other Name_____

Date of Birth: _____ Phone #:_____

Address:_____

City:_____ State:_____ Zip:_____

Health Information Release

☐ I authorize Brazos Valley Mental Health and Wellness to RECEIVE information FROM:
☐ I authorize Brazos Valley Mental Health and Wellness to RELEASE information TO:

Provider/Person/Organization Name:_____

Address:_____ City_____ State: _____ Zip: _____

Phone: _____ Fax _____

Provider/Person/Organization Name:_____

Address:_____ City_____ State: _____ Zip: _____

Phone: _____ Fax _____

Purpose of Disclosure

☐ Continuity of Care ☐ Client Request ☐ Legal Attorney ☐ Parole/Probation

☐ Other-please explain: _____

Health Information to Release

☐ Entire Health Record

☐ Part of Health Record (check one or more items)

☐ Mental Health Diagnostic Assessment
☐ Mental Health Progress Notes/Discharge Summary
☐ Chemical Health Rule 25 Assessment/Diagnosis/Summary
☐ Chemical Health Progress Notes/Discharge Summary
☐ Chemical Health Treatment Plan
☐ Chemical Health Collateral
☐ Mental Health Treatment Plan
☐ Psychological Evaluation
☐ Physical Health Records
☐ Completion Certificate
☐ Billing/Payment Records
☐ Other (please describe):_____

This authorization only covers the period from _____ to _____

Authorization

This authorization will expire no more than 12 months from the date I sign this form unless otherwise specifically permitted by law.
I understand that:

- I have the right to revoke this authorization IN WRITING at any time.
- A revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurance has a legal right to contest a claim.
- Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- That my treatment, payment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- Until payment has been made no information will be released.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name of Legal Representative Relationship to Client