**BAYLOR PSYCHOLOGY CLINIC AND THE BAYLOR PSYCHOLOGY SOCIAL DETERMINANTS OF HEALTH CLINIC**

One Bear Place #97242 Phone: 254-710-2470

Waco, TX 76798 Fax: 254-757-0627

**CONSENT FOR RELEASE OF INFORMATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S NAME CLIENT’S DOB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S CURRENT ADDRESS CLIENT’S PHONE #

DO HEREBY AUTHORIZE: ***BAYLOR PSYCHOLOGY CLINIC*: One Bear Place #97242, Waco, TX 76798**

\_\_\_\_\_\_\_\_\_\_ TO RELEASE INFORMATION TO

\_\_\_\_\_\_\_\_\_\_ TO RECEIVE INFORMATION FROM

\_\_\_\_\_\_\_\_\_\_ TO RELEASE AND RECEIVE INFORMATION FROM

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME PHONE #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS FAX #

***INFORMATION TO BE RELEASED:***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_\_\_\_\_ | Attendance |  | \_\_\_\_\_\_ | Drug/Alcohol Treatment(Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_ | Clinical Diagnoses (not Drug/Alcohol) |  | \_\_\_\_\_\_ | HIV/AIDS |
| \_\_\_\_\_\_ | Summary of Treatment |  | \_\_\_\_\_\_ | Other(Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_ | All Records |  | \_\_\_\_\_\_ | All of the Above |

The disclosure of verbal or written information authorized here is made for the following purpose:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_\_ | Continuity of care with another provider | \_\_\_\_\_\_ | | Copy of Records send to : |
| \_\_\_ | Providing documentation of services/diagnosis/treatment |  | |  |
| \_\_\_ | Communication for collaboration or treatment planning |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_ | Other(Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder Client records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Signature of Individual or Representative Date

Relationship to Client Date

Witness Date

This release expires in 12 months unless I specify another date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this Authorization at any time by notifying the Baylor Psychology Clinic, and in some instances a written revocation may be required. This authorization will cease to be effective on the date specified in my notification, expect to the extent the Clinic has already acted in reliance upon the release.

I understand that my refusal to sign this Authorization will not jeopardize my right to obtain mental health services except where disclosure of the information is necessary for the treatment.

**Procedure for Records**

Submit Records Release form to : Baylor Psychology Clinic

One Bear Place #97242 Phone : 254-710-2470

Waco, TX 76798 Fax: 254-757-0627

Approximate response time for records request: Up to 15 business days. Fee may apply ($18 – fax/pick up; $25 – certified mail).