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AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

Please be advised that your mental health records constitute privileged information that is protected by the laws of the State of Texas and they may contain information that is protected under Federal Confidentiality Regulations. These records cannot be disclosed without your written consent unless otherwise provided for by Federal regulations. **Authorizing the release of information contained in your mental health records constitutes a waiver of privilege.** You may revoke this consent through written notice but it will not apply to action that has been taken prior to receipt of the revocation. If not revoked earlier or noted below, **this consent form expires ninety days from the date of your signature** or as specified below.

Today's Date: _____ Date of Expiration of Consent: _____

I, _____(DOB ____/____/____), request and authorize Stephanie Cruz-Trevino to:

_____ (Initials) Release/Obtain Information to: _____(Name/Facility)

By: ☐ **Email** ☐ **Phone** ☐ **fax** ☐ **letter**

Regarding the following information from my record of my care and treatment (**Please initial**):

____ Primary reason for treatment ____ Medications ____ Prognoses

____ Assessments/Summary of care ____ Dates of appointments ____ Diagnosis

____ Other (Be Specific): _____

The disclosure as authorized herein is made for the following purpose:

☐ **Education/Work** ☐ **Medical/Continuity of Care** ☐ **Legal/DFPS** ☐ _____

Please note the law prohibits further dissemination or use of these records for other purposes.

STATEMENT

On this, _____ day of, _____, 20___, I have read, or have had read to me, the terms and conditions of this agreement, and fully understand. I do freely, voluntarily and without coercion agree to those terms and conditions contained herein.

_____	_____	_____
Client/Guardian name (PRINT)	Client/Guardian's Signature	Therapist's Signature
_____	_____	_____
Client/Guardian name (PRINT)	Client/Guardian's Signature	Therapist's Signature