Family Counseling Service
Authorization to Release Information

3833 S. Staples, Suite S203, Corpus Christi, TX 78411 Phone: (361) 852-9665 Fax: (361) 852-2794

603 E Kleberg, Kingsville, TX 78363 Phone: (361) 592-6058 Fax: (361) 592-7843

I, _____ give Family Counseling Service/Crime Victims Services
(Print Name) (Date of Birth)

permission to _____release or _____request (*initial choice*) information.

In the following form: (*initial choice*)

_____Written **_____Verbal**

To or from the following Person/Agency:

_____
(Agency/Institution) (Contact Person)

_____
(Address, State, Zip Code)

_____
(Phone Number/Fax Number)

Regarding the following confidential Information: *(circle choice)*

Treatment Diagnosis Medical Psychological test results

Background/History Attendance Progress Other:
_____

For the following client: I am the client My child is the client (Client Name: _____)

For the following purpose:
_____

Special instructions/limitations: _____

** This authorization to release information expires _____90 days/_____180days/_____ 1 year (*initial choice*) from today _____(projected date), or *any time the client chooses* to terminate this agreement by signing and returning to Family Counseling Service a separate document stating the release has expired.
**This authorization to release confidential information may be revoked, upon written notice, at any time. If at any time I revoke this authorization, I understand that information already released with my authorization may continue to be used to complete actions already initiated._____ (*please initial)*
**The information being released may no longer be protected by the Federal privacy law when released to anyone other than a health plan or health care provider. _____ (*please initial)*
**Signing this authorization or not signing will have no affect on treatment or payment of treatment.
**You may refuse to sign this authorization. _____ (*please initial)*
**You may inspect or request a copy of your health information that will be used or disclosed. _____ (*please initial)*
**I understand that I will be given a copy of this form after I sign it. _____ (*please initial)*

_____
(Signature of Client/Legally Authorized Representative) (Today's Date) (Printed Name)

_____
(Relation to client)