

Family Counseling Service
Authorization to Release Information

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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)