River Oaks Academy

10600 Richmond Ave Houston, Texas 77042
Phone (713) 783-7200 Fax (713) 783-7286

AUTHORIZATION TO RELEASE /OBTAIN CONFIDENTIAL INFORMATION

I, ____

(Name of Client) **(Date of Birth)**

hereby freely and voluntarily authorize ____

to release / obtain the following information to / from:

____

(Name)

____

(Address)

____

(City, State, Zip Code – Phone Number)

The reason for this disclosure is ____

My medical records may include information regarding diagnosis and treatment of DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology) or PSYCHIATRIC DISORDERS. I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that federal regulations (42 CFR Part 2) prohibit their making any further disclosure without my written consent, or as otherwise permitted by such regulations. The information to be released includes:

- ☐ Discharge Summary
- ☐ Psychiatric History/Mental Status Examination
- ☐ History and Physical
- ☐ Psychological Testing
- ☐ Treatment Plan
- ☐ Laboratory Reports
- ☐ Physician Orders
- ☐ Other ________________________________

____

I understand that I have the right to inspect and copy any written information disclosed and the right to revoke this consent at any time by giving written notice to River Oaks Academy. I UNDERSTAND REQUESTED COPIES WILL BE SUBJECT TO A REASONABLE FEE. I understand that I may not withdraw authorization for a disclosure that is necessary for the purpose of making payment to the hospital for services provided. This authorization will expire 90 days from the date shown below unless another date is specified.
Specification of the date, event or condition upon which consent expires:

____

Patient Signature Date

____

Parent, Guardian, or Authorized Representative Signature Date

____

Witness Signature Date