Health Center of Southeast Texas

307 N William Barnett Ave	11 Woodland Park Dr	1202 N Travis St	204 West Park Drive Ste 200
Cleveland, Texas 77327	Shepherd, Texas 77371	Liberty, Texas 77575	Livingston, Texas 77351
(P) 281-592-2224	(P) 936-628-1100	(P) 936-334-1185	(P) 936-327-4660
(F) 281-592-2225	(F) 936-628-1188	(F) 936-391-3000	(F) 936-327-4661

RELEASE OF MENTAL HEALTH RECORDS

Patient Name: _____

Parent/Guardian Name if patient is a minor: _____

Patient's Address: _____ City: _____ State: ____ ZIP Code: _____

Birth date: _____ Social Security Number: _____

From: Health Center of Southeast East Texas

☐ To: SELF

Physician's Name/Name of Entity : _____

Street Address: _____

Phone Number: _____ Fax: _____

Purpose or need for the information requested: Continued Care _____ *Insurance* _____ *Legal* _____ *Transfer* _____ *Personal* _____

☐ All Mental Health records ☐ Billing records related to ☐ Other (specify, substance abuse treatment or evaluations/psychiatry records, mental health records)

_____

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Patient Records § 42 CFR Part2, §33 of Public Law 91-616 as amended by Public law 93-282, Texas Health Safety Code §81.103 and Chapter 611, and Texas Administrative Code §54.705 and all other application state and local laws, rules, regulations and cannot be disclosed without my written consent unless provided within these laws or regulations. When my information is sued for disclosed pursuant to this authorization, or it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will NOT be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

I hereby authorize the release of all necessary protected health information indicated to entity disclosed above. I wish for them to be forwarded as soon as possible.

Patient's (Parent/Guardian's) Signature: _____ Date: _____

Signature of Witness: _____