Texas Military Department Counseling Program

Authorization for Disclosure of Protected Information (Release of Information)

Full Name: _____ Date of Birth:_____
Address_____ Telephone:_____
_____ _____

I authorize the TXD Counseling Program to release and obtain information regarding myself
☐ To ☐ From:

_____
_____
_____

The purpose of the disclosure is to:

☐ Assist with evaluation and treatment ☐ Continuity of care

☐ Other (Explain):_____

Information to be released (check appropriate category/categories):

☐ Assessment ☐ Diagnostic Impression

☐ Case Notes ☐ Alcohol/Drug Abuse History

☐ Other _____

I further acknowledge that the information being released was fully explained to me and this consent is given willingly. I understand that all client information is confidential and cannot be disclosed to civilian or Military personnel or agencies without my written consent unless otherwise provided for in state or federal law. I understand that I may revoke this authorization at any time, except to the extent those measures have already been taken to comply with it.

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. I understand that my records may include related drug and alcohol abuse information, which is protected under the Federal Confidentiality Regulations (42 CFR, Part 2). I understand that by signing this form I authorize the release of that information to the requesting party. Disclosure of my records to any person other than that person or organization outlined above is prohibited without my specific consent.

Without my expressed revocation, this authorization will automatically expire 6 months from the date signed or 90 days from the date of case closure.

_____ _____

Signature of Client/Guardian **Date** **Signature of Witness** **Date**