



**Authorization to Request or Disclose Protected Health Information**

*This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to release or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.*

**Information regarding patient for whom authorization is made:**

Full Name: \_\_\_\_\_

Other Name(s) Used: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**I. Permission to Release or Obtain Protected Health Information**

I hereby authorize The Carruth Center to request protected health information from and/or disclose protected health information to the following entities (check all that apply):

- The Parish School**, 11001 Hammerly Blvd, Houston, TX 77043, (713) 467-4696
- Spectrum of Hope**, 11820 Cypress Corner Ln., Suite B, Houston, TX 77065, (281) 894-1423
- Holy Spirit Episcopal School**, 12535 Perthshire Rd., Houston, TX 77024, (713) 468-5138

Other (name, address and contact information): \_\_\_\_\_  
\_\_\_\_\_

Other (name, address and contact information): \_\_\_\_\_  
\_\_\_\_\_

Other (name, address and contact information): \_\_\_\_\_  
\_\_\_\_\_

Other (name, address and contact information): \_\_\_\_\_  
\_\_\_\_\_

Other (name, address and contact information): \_\_\_\_\_  
\_\_\_\_\_

Other (name, address and contact information): \_\_\_\_\_  
\_\_\_\_\_

The information to be disclosed or requested:

- All Records**
- ST, OT, PT or Music Therapy client therapeutic/progress notes
- ST, OT, PT or Music Therapy assessment or evaluation results
- Mental Health records (except psychotherapy notes)

Reason for request or disclosure of protected health information (choose all that apply):

- Treatment/coordination of care
- Personal use
- Employment
- Legal purposes
- School
- Other (specify): \_\_\_\_\_
- Insurance purposes

**II. Pick Up Release**

The following people have permission to pick up my child from therapy. If I have included their information in Part I of this form, my child’s therapists may share information about therapeutic progress or session results at the end of my child’s therapy session(s). Please note, if a person not on this list brings your child to therapy, your child will be released to that same person upon the completion of their therapy session.

**Person 1**

Full Name: \_\_\_\_\_ State ID#: \_\_\_\_\_

State of issuance: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Person 2**

Full Name: \_\_\_\_\_ State ID#: \_\_\_\_\_

State of issuance: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**The individual(s) signing this form agrees and acknowledges as follows:**

- (i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
- (ii) **Effective Time Period:** This authorization shall be in effect from the date of I sign below until authorization is revoked, in writing, by me. Any changes to the information on this form should be reported to The Carruth Center office in writing.
- (iii) **Right to Revoke:** I understand that I have the right to revoke this authorization in full or in part at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- (iv) **Special Information:** This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I authorized on the appropriate lines above. In the event the health information described above includes any of these types of information, I specifically authorize release of such information to the person or entity indicated herein.

**Signature Authorization:** I have read this form (pages 1 – 3) and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURES:**

**Signature:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Date:** \_\_\_\_\_