HOUSTON OCD PROGRAM

Quality care. Compassionate atmosphere.

Request/Authorization to Release Confidential Records and Information

A. Identifying information about me/the patient

Name: _____ Phone: _____ Birth date: _____

Address: _____ Social Security #: _____

Parent/guardian (if applicable): _____

Address and phone of parent/guardian: _____

B. I authorize release TO/FROM:

Person or facility: Houston OCD Program

Address: 708 E. 19th St, Houston, TX 77008

Phone: (713) 526-5055 FAX: (713) 526-3226

TO/FROM:

Person or facility: _____ Address: _____

Phone: _____ FAX: _____

For the purposes of: _____

C. I hereby authorize the sources named above to release verbal and/or written information from the records listed below marked by an X in the boxes below. (The items not to be released have a line drawn through them.)

❑ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug or alcohol abuse:

Date(s) of inpatient admission: _____

Date(s) of outpatient treatment: _____

❑ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.

❑ Treatment plans, recovery plans, aftercare plans.

❑ Social histories, assessments with diagnoses, prognoses recommendations, and all similar documents.

❑ Academic or educational records.

❑ Achievement and other testing results.

❑ Psychiatric evaluations, reports, or treatment notes and summaries.

❑ Report of teachers' observations.

❑ Admission and discharge summaries.

❑ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.

❑ Billing records.

❑ A letter containing dates of treatment(s) and a summary of progress.

I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire 30 days from the date I discharge from treatment.

Signatures:

X_____	X_____	X_____	
Signature of client	Printed name	Date	
_____	_____	_____	_____
Signature of parent/guardian/representative	Printed name	Relationship	Date
_____	_____	_____	
Signature of professional	Printed name	Date	