THERAPY DALLAS

Psychological Services for Children, Adolescents, and Adults

12800 Hillcrest A124, Dallas, TX 75230 • 214-755-6119 • www.therapydallas.com

AUTHORIZATION TO RELEASE/RECEIVE PERSONAL HEALTH INFORMATION*

CHILD'S NAME:_______________________________ BIRTH DATE:____________________

I, ______________________________ hereby give my consent to Therapy Dallas to release and receive personal health information contained in my child's Clinical Record regarding:

☐ mental health ☐ medical history ☐ family history ☐ other: ___________________

To/from:

Psychiatrist: _________________________

Phone: ____________________________

Prior Therapist: _______________________

Phone: ____________________________

Evaluator: ___________________________

Phone: ____________________________

Other: ____________________________

Relationship to Patient: _________________

Phone: ____________________________

Pediatrician: _________________________

Phone: ____________________________

for the purpose(s) of ("Consultation" if left blank):

____ .

In addition to authorizing my child's therapist to consult with the above-listed individuals *outside Therapy Dallas*, I also give my consent for my child's therapist to exchange with the below *Therapy Dallas therapist(s)* personal health information contained in my child's Clinical Record, for the purposes of clinical consultation:

Therapy Dallas Therapist(s): ____

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I understand that this authorization is valid for 1 year after the last date of service unless otherwise indicated here: _____________ . I understand that I may, via written request, withdraw my consent at any time, and that I have a right to receive a copy of this authorization form. I also understand that the information being disclosed pursuant to this authorization to individuals outside Therapy Dallas may be subject to redisclosure by the recipient, and may no longer be protected by this privacy rule.

___________________________ ___________________________ ____________

Name of Parent/Guardian, relationship Signature Date

___________________________ ___________________________ ____________

Name of Parent/Guardian, relationship Signature Date

* Compliant with the *Health Insurance Portability and Accountability Act* (HIPAA).