



**Authorization for Release of Protected Health Information**

You have the right to refuse to sign this authorization. Treatment, payment, or eligibility of benefits will not be conditional on signing this authorization. You have the right to inspect or copy protected health information to be disclosed. You will receive a copy of the signed authorization.

Child/Youth Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

I authorize Community Partners for Children to obtain, provide, and exchange both written and verbal information regarding protected health information to and with (Initial Below):

- |  |   |
|--|---|
| <input type="checkbox"/> Advocacy Inc                          | <input type="checkbox"/> Presbyterian Children's Home                                 |
| <input type="checkbox"/> Any Baby Can                          | <input type="checkbox"/> Region XIII Service Center                                   |
| <input type="checkbox"/> Austin Recovery Center                | <input type="checkbox"/> Rio Grande Counseling Center                                 |
| <input type="checkbox"/> ARC of the Capital Area               | <input type="checkbox"/> Seton Shoal Creek Hospital                                   |
| <input type="checkbox"/> Austin/Travis county Advocate Program | <input type="checkbox"/> Southwest Keys   |
| <input type="checkbox"/> Austin Child Guidance Center          | <input type="checkbox"/> Texas Department of Family & Protective Services             |
| <input type="checkbox"/> Austin Regional Clinic                | <input type="checkbox"/> Texas commission for the Blind                               |
| <input type="checkbox"/> Austin State Hospital                 | <input type="checkbox"/> Texas NeuroRehab Center                                      |
| <input type="checkbox"/> Austin/Travis County MHMR             | <input type="checkbox"/> Texas Department of Health                                   |
| <input type="checkbox"/> Austin Independent School District    | <input type="checkbox"/> Texas Department of Human Services                           |
| <input type="checkbox"/> Caring Family Network                 | <input type="checkbox"/> Texas Rehabilitation Commission                              |
| <input type="checkbox"/> Casey Family Foundation               | <input type="checkbox"/> Texas Youth Commission                                       |
| <input type="checkbox"/> Federation of Families                | <input type="checkbox"/> Texas Mentor   |
| <input type="checkbox"/> Health & Human Services Commission    | <input type="checkbox"/> The Children's Partnership                                   |
| <input type="checkbox"/> _____ Independent School District     | <input type="checkbox"/> The Oaks Treatment Center                                    |
| <input type="checkbox"/> Lifeworks                             | <input type="checkbox"/> Travis County Juvenile Probation Department                  |
| <input type="checkbox"/> Lutheran Social Services              | <input type="checkbox"/> Travis County Health and Human Services and Veteran Services |
| <input type="checkbox"/> Meridell Achievement Center           | <input type="checkbox"/> TRIAD  |
| <input type="checkbox"/> Peoples Community Clinic              | <input type="checkbox"/> Other _____  |
|  | <input type="checkbox"/> Other _____  |

Disclosed information limited to (Please initial below):

- |  |   |
|--|---|
| <input type="checkbox"/> Determination of Mental Retardation | <input type="checkbox"/> Narrative Assessments  |
| <input type="checkbox"/> Psychiatric Evaluation              | <input type="checkbox"/> Medication Information |
| <input type="checkbox"/> Treatment Plan                      | <input type="checkbox"/> Treatment Plan Reviews |
| <input type="checkbox"/> Staff Progress Notes                | <input type="checkbox"/> Doctor Progress Notes  |
| <input type="checkbox"/> Diagnosis                           | <input type="checkbox"/> HIV/AIDS Information   |
| <input type="checkbox"/> Substance Abuse Information         | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Psychological Assessment            |   |

The purpose of gathering this information is to assist the Community Partners for Children in understanding the service needs of my child and family.

This authorization can be cancelled at any time, in writing, to Community Partners for Children. However, the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. Community Partners for Children cannot control how the protected health information will be used by the agency/person who receives it under this authorization.

Expiration Date of this Release: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

CPC Representative \_\_\_\_\_ Date \_\_\_\_\_