REQUEST AND AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize and request release of confidential information regarding the medical, psychiatric or psychological evaluation, history and treatment of:

PATIENT'S NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ SS#: _____
NAME CHANGE (if any): _____

Information to be released **TO**:	Information to be released **FROM**:
High Plains Children's Home & Family Services, Inc.	_____
Name of Organization	Name of Person/Organization
11461 S. Western Street	_____
Address	Address
Amarillo, Texas 79118	_____
City State Zip	City State Zip
806-622-2272 806-622-0380	_____
Telephone Fax	Telephone Fax
_____ _____	A photocopy of this release is as valid as the original.
Date(s) of Treatment	Date of Authorization Expiration

PURPOSE FOR RELEASE/EXCHANGE:

_____ Diagnosis/Treatment	_____ Referral	_____ Education Purpose	_____Legal
_____ Insurance Purposes	_____ Aftercare	_____ Social Work	_____Consultation
_____ Patient Request	_____ Evaluation		

INFORMATION TO BE REQUESTED/RELEASED/EXCHANGED:

_____ History & Physical	_____ Physical Therapy	_____ Psychiatric Evaluation
_____ Discharge Summary	_____ Dates of Hospitalization Only	_____ Psychological Test Reports
_____ Operative Report	_____ Diagnosis	_____ Treatment Plans/Progress
_____ Pathology	_____ Legal Documents	_____ Initial Psychiatric Assessment
_____ Consultation	_____ Immunization Records	_____ Social History
_____ Lab & X-Ray	_____ Educational Records	_____ Packet_____
_____ Medication Record	_____ Educational Tests	_____ Other_____
_____ Progress Notes	_____ School Transcripts	

The information or medical records to be covered by this release include test results for AIDS< HIV infection, antibodies to HIV, Or infection with any other probable causative agent of AIDS, and patient expressly authorizes their release pursuant to the Communicable Disease Prevention and Control Act, 81.103 of the Health and Safety Code, V.T.C.A.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical information is not sufficient. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand and agree that no liability of any nature shall attach to the releasing organization or person, to any physician or surgeon or mental and /or health professional, in release of this information, or to any employee of any of them acting upon this request.

_____/ _____
Signature of Patient, Parent, Legal Guardian or Personal Representative Date
Legal Guardian or Personal Representative must produce legal document of authority.

_____/ _____
Witness Title

Sent By:

_____Fax	_____With Patient
_____Mail	_____Optical Disk
_____ Pick Up	_____ Courier_____
_____Verbal	