Texas Premier Counseling Services

MAILING Address:
190 E. Stacy Rd., Suite 306 #325
Allen, TX 75002

FRISCO Address:
2770 Main St., Suite 150
Frisco, TX 75033

www.TexasPCS.org
Phone: (972) 895-2502
FAX: (972) 649-4434
Support@TexasPCS.org

RELEASE OF INFORMATION FORM

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO (PERSON / ORGANIZATION NAME): _____

Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Phone: (_____) _____ Cell Phone: (_____) _____ Fax: (_____) _____

CLIENT / INDIVIDUAL NAME: _____ **DOB**: _____
First *Middle* *Last*

I the undersigned, hereby authorize **Texas Premier Counseling Services** to disclose to and/or acting on my behalf, obtain from the above-named person or organization any/all records and/or information about the above client(s) in the following areas:

☐ Consultation Reports ☐ Discharge Summary ☐ Itemized Bill ☐ Progress Notes ☐ Other: _____

The information specified above is to be released for the following purpose(s):

☐ Treatment ☐ Patient Request ☐ Attorney ☐ Billing or Claims

I ☐ (DO) ☐ (DO NOT) authorize the release of record(s) that have been obtained by my counselor from other providers.

The purpose of this disclosure of information is at the request of the individual. Dates of service include the entire lifetimes(s) of the above-named persons(s). This release is effective until completion of services unless otherwise revoked. A copy or fax of this authorization is as valid as the original. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this form.

The person signing this form will be responsible for any fees incurred from this request. I understand information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by HIPAA privacy regulations. I consent to redisclosure of any information protected by 42 CFR part 2. I acknowledge that this authorization may be revoked via written notice at any time by sending written notification to Texas Premier Counseling Services at the above address. I understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. I acknowledge I have read this form, agree to the uses and disclosures of the information described, and was offered a copy of this authorization for my records.

Signature of Individual \ Legally Authorized Representative

Date

☐ Self ☐ Parent of Minor ☐ Guardian ☐ Other

Printed Name of Legally Authorized Representative

Relationship:

Signature of Minor Individual (*if applicable*)

Printed Name of Minor Individual

Date