CONSENT TO RELEASE OR OBTAIN INFORMATION

I _____ request and authorize	**PLATFORM BEHAVORAL SUPPORT SERVICES** **9896 Bissonnet St. (Ste 410)** **Houston, TX 77036** **Phone: 713-360-7375** **Fax: 888-825-9884**

to ☐ obtain healthcare information or ☐ release healthcare information of the recipient named above from/to:

Name: (Emergency contact Information)

Address:

City/State/ Zip:	Phone:	Fax:

This request and authorization applies to:

☐ All Healthcare information relating to the following treatment, condition, or dates:

☐ Clinical Evaluation	☐ Psychological Evaluation	☐ Psychiatric Evaluation
☐ Social History	☐ Medical History, Examination, Reports	☐ Discharge Summary
☐ Laboratory Results	☐ Quarterly Summary	☐ Treatment Plan
☐ Doctor's Progress Notes	☐ Pharmacy Notes	☐ Other _____

This consent is subject to written revocation at any time except to the extent that action has already been taken in reliance upon this consent. This authorization shall expire on _____ (date or event). I understand that if I do not specify an expiration date/event, this authorization shall expire one year from the date of consent.

I understand that the treatment/services are not contingent upon my signing or not signing this authorization. I freely and voluntarily give my authorization for the release of information from my health record. I also understand and authorize that this information may be sent via facsimile transmission.

TO PARTIES RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR, Part 2) prohibit you from making further disclosures of it without specific written consent of the person to whom it pertains. A general authorization for the release of health or other information is not sufficient for this purpose.

Recipient / Legally Responsible Person Signature:	Date Signed:
Agency Representative Signature:	Date Signed: