Compassionate & Integrated Mental Health Care

Hope Speaks, PLLC
medicalrecords@hopespeaks.com
1200 East Collins Blvd. Suite #300
Richardson, Texas 75081
Phone: (972) 669-1733
Fax: (972) 669-1403

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____ **Date of Birth**: _____________________

Address: ____

City: ______________________________ **State:** ______________ **Zip**: ___________ **Phone:** ______________________

Email Address: ____

I HEREBY AUTHORIZE:
(Name of provider AND facility that has my records)

Name/Facility: ___________________________________

Address: ____

____

Phone: ____

Fax: ____

Email: ____

TO SHARE MY HEALTH INFORMATION WITH:
(Name of person AND facility to receive information)

Name/Facility: ____________________________________

Address: ____

____

Phone: ____

Fax: ____

Email: ____

THIS RELEASE IS FOR:

1. 🕊 **The above entities to ONLY communicate verbally when necessary**

2. 🕊 **An actual copy of the records marked below to be forwarded to the receiving entity:**

🕊 Complete Record 🕊 Initial Evaluation 🕊 Progress Notes 🕊 Lab Reports 🕊 Written Reports (Letters, Completed Forms, Etc.)

🕊 Billing Records (Financial Histories, Fee Tickets, Etc.) 🕊 Other (Specify)____

THE PURPOSE OF THIS RELEASE IS TO:

🕊 Change mental health providers 🕊 Have a copy for my personal records 🕊 Help with divorce/custody issues 🕊 Help with disability claims

🕊 Help with school issues (ARD meetings, extra testing time, etc.) 🕊 Share information with my PCP or another medical provider

🕊 Aid with Criminal/Civil legal cases 🕊 Other;____

I hereby authorize Hope Speaks, PLLC to release/obtain medical information regarding my care and treatment in the manner stated above. I also acknowledge that I have been advised of the notifications and the revocation process as stated on the back of this page.

Printed Name and relationship to patient _______________ Signature _______________ Date _______________

*** PATIENTS, PLEASE BE SURE AND SEE PAGE 2 OF THIS RELEASE *****

NOTICE

Hope Speaks, PLLC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.
I understand that this authorization applies to all records created in the course of my treatment, including information regarding my medical condition and treatment, mental health, alcohol/drug abuse diagnosis and treatment, and communicable disease status, including AIDS/HIV.
In consideration of the release of information by Hope Speaks, PLLC in accordance with this request, I hereby release Hope Speaks, PLLC its agents, servants, and employees from any and all claims, demands, or liability of any kind which might arise out of the release of such information and the effects thereof.

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Expiration of Authorization: **This authorization remains in affect until we receive your written authorization to revoke this release.** The revocation will take effect when Hope Speaks, PLLC receives it, except to the extent Hope Speaks, PLLC or others have already released the information. You are entitled to receive a copy of this Authorization. Authorization may be revoked at any time. **The revocation must be in writing, signed by you or your patient representative, and delivered to:**

Hope Speaks, Medical Records Department
medicalrecords@hopespeaks.com
1200 E. Collins Blvd., Suite 300
Richardson, TX. 75081
Fax: 972) 669-1403

For Hope Speaks Use Only (check applicable):

Records Request was:

☐ Mailed to address on page 1 Date mailed___________ Initials: ________

☐ Faxed to number on page 1 Date Faxed ___________ Initials: ________

Records Released:

☐ Mailed to address on page 1 Date Mailed ___________ Initials: _______

☐ Faxed to number on page 1 Date Faxed ___________ Initials: _______

☐ Picked up at office Date Ready___________ Initials:________

Request for Verbal Communication Only:

☐ Filed Release in chart Date filed___________ Initials:_________

Records not released:

Reason**:** ____

Filed Release in chart: Date filed___________ Initials:_________