**Permission to Release Health Information**

Completing this form gives permission to the CASA program named below to review health information that you choose to be released to them. Please read this entire form before signing.

Full Name: Click or tap here to enter text.

Address: Click or tap here to enter text.

Other Names: Click or tap here to enter text.

Date of Birth: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

Relationship to Child/ren: Click or tap here to enter text.

I, Click or tap here to enter text. authorize Click or tap here to enter text. (CASA program name), its staff, and the volunteer(s) assigned to my case to obtain my health records as indicated by my choices below. I understand that release of my health information is for the limited purpose of permitting the above CASA program to make oral and written recommendations to the court regarding the best interest of the child, pursuant to the court’s order appointing CASA for this purpose.

I give permission to the following person/organization/health service provider to disclose or electronically disclose my protected health information to the above CASA program. Disclosure is limited to the options selected below.

Person/Organization/Service Provider: Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone: Click or tap here to enter text. Email: Click or tap here to enter text.

I permit disclosure of the following information as indicated by the check mark next to my choices:

All health information

Physician’s orders

Records & progress notes

Evaluation/diagnostic & lab reports

Past/present medications

Psychological/psychiatric evaluations

Educational records (Parent/Caregiver)

Adult probation records

Criminal records (unless there is an ongoing criminal investigation or prosecution)

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission to release the following as indicated by my initials below:

\_\_\_\_\_Mental health records (except psychotherapy notes)

\_\_\_\_\_Drug, alcohol, or substance use records (permission and consent to use these records in legal proceedings between DFPS and the person/parent)

**Duration:**  I understand that this Permission to Release Health Information will remain in effect until the conclusion of CASA’s court appointment or until I revoke this Permission in writing.

**Right to Revoke**. I understand that I can withdraw this Permission at any time by giving written notice to CASA stating my intent to revoke. I understand revocation applies to disclosures from the effective date of the written revocation forward. I agree and acknowledge that any prior actions of CASA and the disclosing entities in reliance on this release will not be affected.

I have read and understand this form and agree to the use and disclosure of the information as described.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Revocation or Withdrawal of Permission to Release Information**

Date of Revocation or Withdrawal: \_\_\_\_\_\_\_\_\_\_\_\_ Time of Revocation or Withdrawal: \_\_\_\_\_\_\_\_\_\_\_\_

Person requesting Revocation or Withdrawal:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Signature