Carlin Speech Pathology & Associates
speaking to the future

**26407 Oak Ridge Dr., The Woodlands, TX 77380 P: (281) 363-2270 F: (281) 292-3902**

## PATIENT INFORMATION

Patient Name: _____ Preferred: _____ Sex: M / F

Date of Birth: _____ Age: _____ SSN: ___ - ___ - _____ □ Single □ Married □ Dependent

Address: _____
Street No. Street Name City State Zip

Dominant Language: □ English □ Spanish □ Other: _____

Referred by: _____ Phone: ( ) -

Underlying medical Condition? _____

## PATIENT/PARENT/GUARDIAN INFORMATION

Name: _____ Phone: ( ) - □ Home □ Cell

Relation to Patient: _____ Phone: ( ) - □ Cell □ Work

Email: _____ Occupation: _____

Name: _____ Phone: ( ) - □ Home □ Cell

Relation to Patient: _____ Phone: ( ) - □ Cell □ Work

Email: _____ Occupation: _____

## INSURANCE (primary & secondary if applicable)

Insurance Company: _____ Phone: ( ) -

Member/Subscriber ID: _____ Group Name: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____ Relation to Patient: □ Self □ Parent □ _____

Insurance Company: _____ Phone: ( ) -

Member/Subscriber ID: _____ Group Name: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____ Relation to Patient: □ Self □ Parent □ _____

## PRIMARY CARE PHYSICIAN

Physician Name: _____ Phone: ( ) -

Office Name: _____ Fax: ( ) -

Address: _____
Street No. Street Name City State Zip

## Patient Release and Insurance Authorization: (Initials are required for release of Medical Information and Authorization of Payment)

_____ I hereby authorize payment directly to the Center for the benefits due to me in my pending claim and/or Major Medical Benefits otherwise payable to me, but not to exceed the physician's and/or the Institutes regular charges for therapy for this treatment period.

_____ I further authorize the release of any medical information required by my insurance carrier(s) and/or treating physicians.

***Notice: Misrepresentation and/or falsification of essential information requested in this document may be subject to monetary fines and/or imprisonment, if convicted, under federal law.***

My signature Indicates that I have read and understood the packet provided upon my admission to the Center. This packet includes a consent form, insurance and medical release form, and insurance benefits assignment / financial agreement.

_____ _____
Signature of Patient/Parent or Legal Guardian Date



Facility Witness Initials _____

## PATIENT HEALTH HISTORY FORM

Previous Speech/Occupational Therapist: _____ Phone: (  ) -

Present Health Concerns: _____

### PREGNANCY & BIRTH

Where was your child born? _____

Is the child yours by: □ Birth □ Adoption □ Stepchild □ Other: _____

Please indicate any medical problems during pregnancy: □ None □ Specify: _____

Delivered by: □ Vaginal Birth □ Caesarean If Caesarean, Why? _____

Birth Weight: _____ Birth Length: _____ APGAR Score: □ 1 min. □ 5 min.

If Premature, how early? _____

Please indicate any medical problems during the baby's newborn period. □ None □ Specify: _____

Gestational Diabetes? □ Yes □ No Thyroid problems? □ Yes □ No

### NUTRITION & FEEDING

Was your child breastfed? □ No □ Yes If yes, for how long? _____

Has your child had any unusual feeding/dietary problems? □ No □ Yes If yes, specify: _____

Milk Intake Now: □ Cow's milk ( □ Nonfat □ 1% □ 2% □ Whole) □ Soy Milk □ Rice Milk □Goat Milk

□ Other: _____ Average Ounces per day (Note: 8 ounces = 1 cup)? _____

### SLEEP

Hours per night: _____ Naps (number & length): _____ Any sleep problems? _____

### DEVELOPMENT

At what age did your child: Crawl: _____ Sit Alone: _____ Walk Alone: _____ Say Words: _____

*Girls only:* Age of first menstrual period: _____

### DENTAL HISTORY

Has child been seen by a dentist? □ No □ Yes If so, how often? _____

Date of last visit: _____ Dental problem: _____

### VISION

Have you/your child (the patient) had a formal vision check? □ No □ Yes If yes, date of check: _____ Results: _____

Do you have any concerns regarding vision (color blindness etc.)? □ No □ Yes If so, what are your concerns? _____

Do you/your child (the patient) require corrective lenses? □ No □ Yes If so, what for? _____

Any history of vision changes or cortical vision impairments? □ No □ Yes If so, please explain: _____

### HEARING

Have you/your child (the patient) had a formal hearing screening? □ No □ Yes If yes, date of evaluation: _____

Results: _____ **History of:** Ear infections? □ Yes □ No P.E. Tubes? □ Yes □ No Otitis Media? □ Yes □ No

### IMMUNIZATIONS/INFECTIOUS DISEASES

Has your child had: □ Chicken Pox □ Measles □ Mumps □ Rubella □ Meningitis □ Tuberculosis (TB)

Immunizations Current? □ Yes □ No If no, please specify: _____



Facility Witness Initials _____

## EXPOSURE/HABITS

Any concerns about lead exposure? (old home, plumbing, peeling paint) □ No □ Yes

Do any household members smoke: □ No □ Yes TV hours per day: _____ Video game-hours per day: _____

## ☐ Not Applicable PAST MEDICAL HISTORY

Please describe any major medical problems and their dates: _____

Hospitalizations/Operations such as Frenectomy, Tonsillectomy, Adenoidectomy (with dates):

| Procedure | Date | Doctor/Facility |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Broken bones or severe sprains: _____

## ☐ Not Applicable SCHOOL HISTORY

Does your child attend school or preschool? □ No □ Yes: □ Home school □ Has in the past

Current Grade: _____ Name of school: _____

Has your child received speech therapy within the last year in the public-school system? □ No □ Yes

Has your child received occupational therapy within the last year in the public-school system? □ No □ Yes

Any concerns about school performance? _____

Any concerns about relationships with: □ None □ Teachers □ Students If any, please explain: _____

If more than 4 years old, does your child have a best friend? □ No □ Yes

Sports/exercise type, if any: _____

How often? _____ How long? (min.) _____

## ☐ None REVIEW OF SYMPTOMS: Please check any current problems you (the patient) has on the list below.

**Constitutional:**
□ Fever/Chills/Excessive sweating
□ Unexplained weight loss/gain

**Eyes:**
□ Squinting/"crossed" eyes/asymmetric gaze

**Ear/Nose/Throat:**
□ Unusually loud voice/hard of hearing
□ Mouth breathing/snoring
□ Bad Breath
□ Frequent runny nose
□ Problems with teeth/gums

**Cardiovascular:**
□ Tires easily with exercise
□ Shortness of breath
□ Fainting

**Respiratory:**
□ Cough/wheeze
□ Chest pain

**Gastrointestinal:**
□ Nausea/vomiting/diarrhea
□ Constipation
□ Blood in bowel

**Genitourinary:**
□ Bedwetting
□ Pain in urination
□ Any discharge

**Skin:**
□ Rashes
□ Unusual moles

**Musculoskeletal:**
□ Muscle/joint pain

**Allergy:**
□ Hay fever/itchy eyes

**Neurological**
□ Headaches
□ Weakness
□ Clumsiness

**Psychiatric/Emotional**
□ Speech problems
□ Anxiety/stress
□ Problems with sleep, nightmares
□ Depression
□ Nail biting/thumb sucking
□ Bad temper/breath holding/jealousy

**Blood/Lymph:**
□ Unexplained lumps
□ Easy bruising/bleeding



Facility Witness Initials _____

☐ **None** **FAMILY HISTORY** (Please check all that apply)

| Medical Condition | Patient | Dad | Mom | Brother | Sister | Maternal Grandpa | Maternal Grandma | Paternal Grandpa | Paternal Grandma | Aunt | Uncle |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcoholism | | | | | | | | | | | |
| Asthma | | | | | | | | | | | |
| Autoimmune Disorder | | | | | | | | | | | |
| Bleeding Problem | | | | | | | | | | | |
| Cancer, Breast | | | | | | | | | | | |
| Cancer, Melanoma | | | | | | | | | | | |
| Cancer, Ovary | | | | | | | | | | | |
| Congenital Anomaly/ Birth Defect | | | | | | | | | | | |
| Heart Attack/Heart disease | | | | | | | | | | | |
| Depression | | | | | | | | | | | |
| Diabetes (on insulin) | | | | | | | | | | | |
| Diabetes (no insulin) | | | | | | | | | | | |
| Eczema | | | | | | | | | | | |
| Food Allergy | | | | | | | | | | | |
| Genetic Disorder | | | | | | | | | | | |
| Hepatitis B | | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | |
| Immune Disorder | | | | | | | | | | | |
| HIV infection | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | |
| Mental Retardation / Learning Disability | | | | | | | | | | | |
| Stroke | | | | | | | | | | | |
| Substance Abuse | | | | | | | | | | | |
| Thyroid Disorders | | | | | | | | | | | |
| Tobacco Use | | | | | | | | | | | |
| Tuberculosis (TB) | | | | | | | | | | | |
| Death before age 56 for reason not listed | | | | | | | | | | | |
| Other | | | | | | | | | | | |

## SOCIAL HISTORY

**Who lives at home?**

| Name: | Age: | Relationship: | Highest Level of Education: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are your child's parents: □ Married □ Unmarried □ Separated □ Divorced If divorced or separated, when? _____



Facility Witness Initials _____

☐ **Not Applicable**

**Childcare situation**: □ Parents □ Grandparents □ Other (specify who & hours per day): _____

Concerns about your child: _____

**Is violence at home a concern:** □ No □ Yes **Are there guns in the home?** □ No □ Yes

**Are there any eating concerns** (picky eater, avoidance of food textures or tastes, drooling, poor control of food in mouth)?

**DRESSING:**

**Removes:**

**Shoes:** □ Yes □ No □ Needs help **Shirt/Jacket** □ Yes □ No □ Needs help **Pants**: □ Yes □ No □ Needs help **Underpants**: □ Yes □ No □ Needs help

**Puts on:**

**Shoes:** □ Yes □ No □ Needs help **Shirt/Jacket** □ Yes □ No □ Needs help **Pants**: □ Yes □ No □ Needs help **Underpants**: □ Yes □ No □ Needs help

**Describe any help needed:**

**Please describe any additional concerns (if any):** ☐ **None**

_____

Patient Name (Please print)

_____ _____

Signature of Patient/Parent or Legal Guardian Date



Facility Witness Initials _____

**PATIENT CONTINUITY OF CARE AND RISK CLASSIFICATION FORM**

PATIENT NAME: _____ AGE: _____ DATE OF BIRTH: _____

**ALLERGIES:**

☐ NO KNOWN DRUG ALLERGIES (NKDA)

☐ DRUG ALLERGIES: _____

_____

☐ OTHER ALLERGIES: _____

| MEDICATION | DOSAGE / FREQUENCY | REASON FOR MEDICATION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PATIENT'S BLOOD TYPE:** [CIRCLE PATIENT'S BLOOD TYPE]

A + A- B+ B- AB+ AB- O+ O- NOT KNOWN

**ADVANCE DIRECTIVE PREFERENCE**: [CHECK ONE ANSWER]

□ THE PATIENT DOES NOT HAVE AN ADVANCE DIRECTIVE PREFERENCE

□ THE PATIENT DOES HAVE ADVANCE DIRECTIVE PREFERENCE (PROVIDE COPY TO CLINIC)

**EMERGENCY CONTACTS:**

| NAME | PHONE NUMBER | RELATION TO PATIENT |
|---|---|---|
| | ( ) - | |
| | ( ) - | |
| | ( ) - | |

**During disaster situations, therapy may be postponed for up to:**
8 hrs**.- level 1**; postponed for 9-48 hrs. **level 2**; postponed for 49-71 hrs. **level 3**; postponed for 72-96+ hrs. **level 4.**

**FACILITY EMERGENCY CLASSIFICATION**: 4



Facility Witness Initials _____

**Patient Name** _____

## ADMISSION FORM
## COMPREHENSIVE TREATMENT PLAN AGREEMENT

The following is a description of this clinic's policies regarding the comprehensive treatment plan. Please read and indicate your agreement to abide by these policies by initialing and signing where indicated. If you have any questions about these policies, please ask a representative of this clinic before signing.

### Non-Discrimination Policy

The Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, and activities, or in employment. For further information, contact the Front Office Supervisor or TTY State Relay at 1-800-735-2988.

Speech, Hearing and Visual assistance communication guides are available at no charge and upon request. For further information, contact the Front Office Supervisor or TTY State Relay at 1 800 735-2988.

Initials _____

### Scheduling Policy and Consent to Treat

I, the Patient/Parent or Legal Guardian hereby consent to treatment for therapy services. **I further understand that once a weekly treatment appointment schedule has been determined; this clinic is often unable to accommodate changes for temporary periods of time. When a permanent change in time is needed, I must give as much advanced notice as possible for the clinic to attempt to accommodate this request. A change in time may necessitate a change in therapists as well.**

I understand that in order to receive maximal benefit from treatment, it is important for treatment to occur as recommended by the therapist. I understand that I have up to two weeks from the time of cancellation to make up for the cancelled session. I understand that I will lose the cancelled session if not made-up within two weeks. **I understand that a make-up session may occur with this clinics substitute therapist, our regular therapist, or another skilled therapist with this clinic and may be offered as a separate session or by adding on additional time to several sessions.**

I understand that notification of vacations or family obligations is requested at least two weeks prior to the expected absence, to facilitate rescheduling our appointment(s). I understand that we are entitled to make up sessions for vacation time two weeks before or following our vacation time.

I understand that the clinic is open except in cases of severe weather conditions requiring businesses to close. It is my responsibility to call the clinic to determine whether changes in the scheduled time of treatment are needed and if the opening of the clinic has been delayed. Families may cancel treatment if they do not wish to travel in poor weather conditions. I understand that if treatment time falls on a federal holiday that I am encouraged to make up these sessions.

I understand that if our therapist is ill or on vacation, the clinic will provide a substitute therapist to ensure continuation of services. This clinic will make every effort to schedule the therapist at our regularly scheduled appointment time. If this cannot occur, the clinic will provide an alternate appointment time.

I understand that if we do not keep a scheduled appointment or if we do not cancel a session before the session is scheduled to begin, that time of treatment is forfeited.

**I understand that consecutive cancellations of appointments of two or more WILL lead to the loss all scheduled reoccurring appointment times. I also understand that I will be held responsible for scheduling these appointments weekly for a time period of up to one month.**

By initialing I confirm that I have read and agree to abide by the above policies.

Initials _____



Facility Witness Initials _____

**Office Policy for Families with Child Clients**
I understand that infants and toddlers often need to be accompanied by a parent during treatment; all other individuals are asked to please wait in the waiting room during treatment sessions. Observations of my child's treatment session may be scheduled upon request.

I understand that I am responsible for waiting with my child in the waiting room until the treatment session begins and monitoring my child's play in the waiting room. I understand that the clinic prefers I wait during the session so that I am able to monitor some of my child's treatment when appropriate. I understand that it is the policy of this clinic that a parent or legal guardian must remain in the clinic during treatment sessions.

Initials _____

**Acknowledgement of Risk**
I understand that there is some risk inherent in the use of therapeutic equipment at this clinic, and I agree to indemnify and hold the clinic harmless for any and all losses and claims for any injuries occurring to my child or myself from the use of therapeutic equipment.

Initials _____

**Coordination of Care**
I give permission to have this clinic contact and discuss my child's/my case with all persons whose names I have provided as professionals working with my child or myself.

Initials _____

I give permission for this clinic to send copies of progress reports to all referral sources whose names I have provided.

Initials _____

**Teaching and Education of Students**
I give permission for occupational, physical, and speech therapy students to observe me or my child's therapy. I understand that I will be notified before such observation takes place.

Initials _____
☐ **Decline**

**Consent to Photograph**
I give permission for photographs/videotapes to be taken of myself, or my child for educational and/or promotional purposes. I understand that any photographs or videotapes will be reviewed by me before they are released.

Initials _____
☐ **Decline**

**Financial Responsibility**
PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE
I agree to be responsible for payment of all services rendered. I authorize release of any medical information necessary to process my claims. I authorize payment of medical benefits to Carlin Speech Pathology & Associates, Inc. for services provided.

_____
Patient Name (Please print)

_____ _____
Signature of Patient/Parent or Legal Guardian Date



Facility Witness Initials _____

## NOTICE OF HIPAA PRIVACY PRACTICE CONSENT

I HEREBY CONFIRM THAT THE HIPAA POLICY HAS BEEN PROVIDED TO THE CLIENT/PARENT/GAURDIAN AT TIME OF THIS ADMISSION

**CHANGES TO THIS NOTICE**

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with Carlin Speech Pathology & Associates, Inc. or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with Carlin Speech Pathology & Associates, Inc. contact the Privacy Officer at 281-363-2270. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred.

The address for the Office of Civil Rights is:

**Centralized Case Management Operations**
**U.S. Department of Health and Human Services**
**200 Independence Avenue, S.W.**
**Room 509F HHH Bldg.**
**Washington, D.C. 20201**

All complaints should be submitted in writing.
You will NOT be penalized for filing a complaint.

- - - -

## SPEECH THERAPY COMPLIANT NOTICE ACKNOWLEDGEMENT

As required by the Texas Administrative Code for Speech-Language Pathology and Audiology, article §741.45 regarding Consumer Information and Display of License, we hereby provide you with the following information on how to file a consumer complaint:

A PERSON WHO PROVIDES SPEECH-LANGUAGE PATHOLOGY AND/OR AUDIOLOGY SERVICES TO CLIENTS MUST BE LICENSED, UNLESS EXEMPTED BY STATE LAW.

A CONSUMER WHO WISHES TO FILE A COMPLAINT AGAINST AN INDIVIDUAL LICENSED BY THE BOARD MAY VISIT:

**https://www.tdlr.texas.gov/complaints/**

**OR**

**FAX TO:**
**(512) 539-5698**

**OR**

**WRITE TO:**
**TDLR (ENFORCEMENT DIVISION)**
**P.O. BOX 12157**
**AUSTIN, TX 78711-2157**

**OR**

**SEND BY DELIVERY SERVICE TO:**
**TDLR**
**920 COLORADO ST**
**AUSTIN, TX 78701-2332**

Speech Therapy Consumer Complaint information given to patient/parent or legal guardian.

_____
Patient Name (Please print)

_____ _____
Signature of Patient/Parent or Legal Guardian Date



Facility Witness Initials _____

## ADVANCE DIRECTIVES POLICY

Carlin Speech Pathology & Associates, Inc. requires each person receiving treatment in this facility to sign the following notice to follow the Self-Determination Act regarding advance directives. In this facility should a patient suffer a life-threatening situation this signed notice implies agreement on the resuscitation and transfer of the individual to a higher medical care. If in the event the person has an Advance Directive and has provided it to our office, we will honor the patient's directive. Any further concerns regarding
this policy should be addressed with your physician.

I have read the above policy and understand the information in this policy.

Initials _____

## 211 EMERGENCY DISASTER PROGRAM ASSISTANCE

Please indicate who will be registering the client with 2-1-1 Emergency Disaster Services provided through the Texas Department of State Health Services.

- ☐ Patient/Parent/Guardian
- ☐ Family Member/Power of Attorney
- ☐ Facility Representative
- ☐ I decline to register the patient for 211 services
- ☐ Other: _____

Initials _____

## ACKNOWLEDGMENT OF RECEIPT OF POLICIES

1. Notice of Privacy Practices
2. Statement of Patient Bill of Rights
3. Sick Policy Consent
4. Patient Responsibilities
5. Advance Directive Policy
6. Advance Directive and Do Not Resuscitate Orders
7. State of Emergency Assistance Registry (STEAR)

I acknowledge that **Carlin Speech Pathology & Associates, Inc.** provided me with a written copy of the above policies and was afforded the opportunity to read and ask questions.

_____
Patient Name (Please print)

_____ _____
Signature of Patient/Parent or Legal Guardian Date



Facility Witness Initials _____

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

**Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.** Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

**NAME OF PATIENT OR INDIVIDUAL**

_____
Last First Middle

**OTHER NAME(S) USED** _____

**DATE OF BIRTH** Month _____ Day _____ Year _____

**ADDRESS** _____

_____

**CITY** _____ **STATE** _____ **ZIP** _____

**PHONE** (_____)_____ **ALT. PHONE** (_____)_____

**EMAIL ADDRESS** (Optional): _____

**I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:**

Person/Organization Name Carlin Speech Pathology & Associates
Address 26407 Oak Ridge Dr
City The Woodlands State TX Zip Code 77380
Phone ( 281 ) 363 - 2270 Fax ( 281 ) 292 - 3902

**WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?**

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

**REASON FOR DISCLOSURE**
**(Choose only one option below)**

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

**WHAT INFORMATION CAN BE DISCLOSED?** Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

**Your initials are required to release the following information:**

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

**EFFECTIVE TIME PERIOD.** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

**RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURE X**_____ _____
**Signature of Individual or Individual's Legally Authorized Representative** **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

**SIGNATURE X**_____ _____
**Signature of Minor Individual** **DATE**