Telehealth Counseling Clinic
4225 TAMU, College Station, TX 77843-4225
Phone: (979) 458-9990 Fax: (979) 458-8445

Confidentiality Release Form

I, ___________________________________, authorize the Telehealth Counseling Clinic (TCC) to exchange information from my health records with the following agency or individual **(check <u>one</u> option below)**:

[1] _______ Myself (requesting copy of my records)

[2] _______ Family member, friend, or caretaker

[3] _______ Physician or health care provider

[4] _______ Health insurance provider

[5] _______ Employer

[6] _______ Disability services office

[7] _______ Other: ___________________________________
(relationship to client)

Contact information for the agency/individual specified above:

[8] ____ (name)

[9] ____ (address)

[10] ____

[11] ____ (phone/fax)

[12] ____

My health information will be exchanged for the following purpose *(for example: care coordination, documentation of services received)*:

[13] ____

____

I understand that I may selectively authorize the release of some of my health records and keep other parts confidential. Restrictions on the scope of this authorization are stated below. If this section is left blank, I am authorizing the release of any part of my health records to the agency/individual specified above as deemed necessary by the Telehealth Counseling Clinic.

[14] ____

____

By signing below,

- I understand and agree that this authorization will be valid and in effect until one year after the end of my treatment at the Telehealth Counseling Clinic, unless otherwise specified in writing. I understand that after that date, no more of this information can be used or released to the agency/individual specified unless I sign a new authorization like this one.
- I understand I can revoke or cancel this authorization at any time by sending a letter to the Telehealth Counseling Clinic. If I do this, it will prevent any disclosures after the date my letter is received but cannot change the fact that some information may have been released before that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the Telehealth Counseling Clinic.
- I understand that I may inspect and have a copy of the health information described in this authorization. There may be a fee for this copy or other services.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information released may be redisclosed and no longer protected by those regulations.
- I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

______________________________	______________
Signature of client or representative	Date
______________________________	______________
Printed name of client or representative	Relationship to the client

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For Staff Use

I have discussed the issues above with the client or the client's personal representative. My observations give me no reason to believe that the client is not fully competent to give informed and willing consent.

______________________________	______________
Signature of TCC Staff or Trainee	Date
______________________________	
Printed name of TCC Staff or Trainee	