TRINITY CHALLENGE

AUTHORIZATION TO RECEIVE OR TO RELEASE INFORMATION

Please be advised that your mental health records constitute privileged information that is protected by the laws of the State of Texas and that they may contain information that is protected under Federal Confidentiality Regulations. These records cannot be disclosed without your written consent unless otherwise provided for in the federal regulations. Authorizing the release of information contained in your mental health records constitutes waiver of a privilege. You may revoke this consent through written notice, but it will not apply to action that has been taken prior to receipt of the revocation. If not revoked earlier or noted below, this consent form remains in effect until further notice.

I, _____
(PLEASE PRINT) LAST NAME FIRST NAME MIDDLE INITIAL

request and authorize: Trinity Challenge, LLC
14903 Robin Road
Haslet, Texas 76052
Phone: 325-829-8281

❑ Release to / from ❑ Discuss with ❑ Email to:

_____ _____
NAME PHONE

_____ _____
STREET ADDRESS FAX

_____ _____
CITY STATE ZIP

the following information from the record of my care and treatment (please check each category that applies):

❑ Counseling and/or psychiatric record
❑ Client status/intake information
❑ Dates of appointments
❑ Other, as specified below
❑ Conversations as needed to facilitate continuity of care

Other: _____

The disclosure as authorized herein is made for the following purpose:_____
Please note that the law prohibits further dissemination or use of these records for other purposes.

On this, the _____ day of _____, 20____, I have read or have had read to me, the terms and conditions of this agreement and fully understand same. I do freely, voluntarily, and without coercion agree to those terms and conditions contained herein.

_____
SIGNATURE OF CLIENT

_____
DATE

_____
PHONE