Lake Worth Counseling
ADULT • CHILDREN • FAMILY SERVICES

4516 Boat Club Road, STE 106
Fort Worth, Texas 76135
Phone (817) 238-0106 Fax (817) 238-8333

MENTAL HEALTH RECORDS RELEASE FORM 05/2019

How to Get My Records & Who Must Authorize Release of Information

Please complete this form in full to request a release of information or to obtain a copy of your mental health records. Individuals over the age of 18 must authorize the release of their own information.

Written Authorization:

- Complete all information as requested. Sign and date the authorization using your full legal signature.
- Turn in form in person, by fax or email to: LWC Medical Record Release, fax to 817-238-8333 or email to info@lwc.care .
- **A fee may be required for records release. The fee may be paid by cash or credit card and must be paid in person or by phone with a credit card prior to processing your records request.**

(✓)	RECORDS REQUEST	FEE
	Records Request	$70.00
	Legal Records Request	$130.00 (hourly rate)
	Work/School Work Letter	$130.00
	Counselor Professional Letter	$130.00
	Dr. Jon Shepard Professional Letter/Form	$135.00 (hourly rate)
	Legal/Court Letter (1-2 page letter)	$150.00 - $300.00
	Short -Term Disability Form	$130.00
	Notary or Certified Mail Fee	$35.00
	Attorney Phone Consultation Fee	$150.00 (up to 50 min.)
	FMLA	TBD

Time for Release

It may take up to 10 days to process a records request. If you plan on picking up the records, please call ahead of time to ensure they are ready when you arrive. You must provide a valid picture identification card when picking up records from our office. Fees include cost of materials and labor. All fees must be paid in advance. If you have any questions, please contact a member of our support staff (817) 238-0106.

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AUTHORIZATION (PAGE 2 OF 2)

1). Name of person making request:__________Relationship to client: ___________

Address: ___________ City: ________ State: ___ Zip:_____ Phone:__________

2). I authorize Lake Worth Counseling to release or obtain information concerning myself/minor: _________________________ ________________
Client Name Date of Birth

3). The information specified below may be released TO or FROM the following (self, spouse, school, work, doctor's office, attorney):

Name/Company: ____________________ Relationship to client: ____________

Address:__________________ City: _________ State: ______ Zip: _________

Phone: ____________ Fax: __________ Email: ___________________________

4). The specific purpose(s) for this records request is (coordination of treatment, parent release, attorney, school consult, etc…) ______________________________________

5). Place a check (√) next to the specific medical information to be released and list the specific dates of treatment:

__ All Health Information
__ Progress Notes
__ Attendance
__ Intake Summary
__ Psychological Test Results
__ Treatment Plan & Diagnosis
__ Billing Information
__ Telephone Consultation

I understand and acknowledge the following statements: I authorize LWC to receive or release my or a minor's mental health records. After the above information is released, it may be re-released by the recipient and the information may no longer be protected by federal privacy laws or regulations. I may be charged a fee for any copies of my mental health records or my child's medical record I request for myself or for use by others. *Fees for copies are due and payable before copies are released.* I may revoke this authorization at any time by notifying LWC in writing to susan@lwc.care ATTN: Susan Shepard Mental Health Records. Unless otherwise revoked in writing, this authorization will EXPIRE one year from the date this form is signed.

Signature of Client/Parent or Legal Guardian: ______________________ **Date:** ___________