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 (9/22)

How to Get Client 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 client mental health records. Individuals over the age of 18 must authorize the release of their own information.

Written Authorization:

- Client to complete all information as requested. Client or parent/legal guardian shall sign and date the authorization.

- Please turn in form in person, by fax or email to: ATTN: CLINICAL SUPERVISOR, RECORDS RELEASE. Office fax 817-238-8333 or sharon@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 prior to processing client's records request.

(x)	RECORDS REQUEST	FEE
	Summary Progress Report & Tx Plan	$145.00
	Counselor Professional Letter	$145.00
	Psychologist Professional Letter/Form	$175.00 (hourly rate)
	Legal Records or Letter	$300.00
	Certified Mail Fee	$35.00
	Attorney Phone Consultation Fee	$225.00 (50 min.)
	Doctor/Specialist referral/brief collaboration of treatment	No fee
	Collaboration with School (counselor, teacher, administrator)	$145.00 or by appointment only
	Administrative Fees/Forms/Attendance Report	$65.00

Time for Release

Request may take up to 10 business days to complete a records request. Client must provide a valid picture identification card when picking up records from office. Fees include cost of materials and labor. All fees must be paid in advance. If you have any questions, please call our office at (817) 238-0106.

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MENTAL HEALTH RECORDS RELEASE FORM AUTHORIZATION (PAGE 2 OF 2)

1). Name of person making request:_____

Relationship to client: _____ Phone: _____

Address:_____ City:_____State:___Zip:_____

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

Client understands and acknowledges the following statement: 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: sharon@lwc.care. 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:** _____