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

Please complete the following to request a release of information or to obtain mental health records. Individuals over the age of 18 must authorize the release of their own information.
A fee may be required and is due before release of records/information.

(x)	REQUEST TYPE	FEE
	Summary Progress Report/Counselor or Psychologist Professional Letter	$150.00-$175.00
	Legal Summary/Report/Records	$300.00
	Certified Mail/Notary Fee	$35.00
	Attorney Phone Consultation Fee	$225.00 (50 min.)
	Collaboration with School (counselor, teacher, administrator)	$150.00 or by appointment
	Administrative Fees/Forms/Written Attendance Report	$65.00
	Doctor/Specialist/Counselor referral/brief collaboration of treatment	NO FEE

Client/Parent requesting release: _____ **DOB:** _____

Relationship to client: _____ **Phone:** _____

Address: _____ **City:** _____**ST:** ___ **Zip:** _____

I authorize Lake Worth Counseling to release or obtain information concerning:

____ Myself ____ Minor: _____ DOB: _____

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

Name/Company: _____ **Relationship to client:** _____

Address: _____**City:** _____**ST:** ____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Please check (√) the specific information to be released:

___ All Health Information
___ Psychological Test Results
___ Progress Notes/Intake
___ Treatment Plan & Diagnosis
___ Attendance
___ Billing Information
OTHER: _____
_____

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.* This consent is valid until the occurrence of the death of the individual, the individual reaching the age of majority, or the consent is revoked. This Consent may be revoked by the person giving authorization through written notice to Susan Shepard at susan@lwc.care except to the extent that action has been already taken in reliance hereon.

Requests may take up to 10 business days to complete, client must present a valid ID when picking up records/reports from the LWC office.

Signature of Client/Parent/Legal Guardian:_____ **Date:** _____