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## CASE COUNSELING, PLLC

Robin Case, LCSW

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### Authorization for Use and Release of Information

To: \_\_\_\_\_

Client(s): \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

I, the undersigned, hereby authorize and request Case Counseling, PLLC to disclose to and/or, obtain from the above-named person or organization any and all records and information about the client(s) named above. I am requesting the following information:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> All health information. | <input type="checkbox"/> Admission summaries  | <input type="checkbox"/> Police records   |
| <input type="checkbox"/> Dental records          | <input type="checkbox"/> Social history       | <input type="checkbox"/> CPS records  |
| <input type="checkbox"/> School information.     | <input type="checkbox"/> Treatment summaries. | <input type="checkbox"/> Probation/parole information                             |
| <input type="checkbox"/> Day care information.   | <input type="checkbox"/> Discharge summaries. | <input type="checkbox"/> Drug, alcohol, substance abuse treatment/testing records |
| <input type="checkbox"/> Mental health record    |   |   |
| <input type="checkbox"/> Other: _____            |   |   |
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The purpose of this disclosure of information is at the request of the individual who signed this Release of Information. Dates of service include the entire lifetime(s) of the above-named person(s). This release is effective until completion of services, unless otherwise revoked. A copy or fax of this authorization is as valid as the original.

**The person signing this form will be responsible for any fees incurred from this request.**

I understand information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by HIPAA privacy regulations. I consent to redisclosure of any information protected by 42 CFR part 2. I acknowledge that this authorization may be revoked via written notice at any time by sending written notification to Case Counseling, PLLC at the above mailing address. I understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. I acknowledge I have read this form, and agree to the uses and disclosures of the information described.

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Printed Name.

Relationship to client(s).

Signature.

Date signed