# *AUTHORIZATION FOR RELEASE OF INFORMATION*

**THE STATE OF TEXAS** **§**
**§**
**COUNTY OF _____** **§**

DATE:_____

This is to authorize any hospital, clinic, physician, doctor, psychologist, psychiatrist, counselor, therapist, or other person or organization who has provided services to _____ at any time, to make full disclosure regarding any services provided, including but not limited to: true and accurate copies of any and all notes, records, photographs, X-rays, correspondence, and reports prepared in the course and scope of all services provided. Such disclosures are to be made to any official representative employed by or associated with the Texas Department of Family and Protective Services who requests the aforementioned information and documentation.

This notice, or a photocopy thereof, may be exhibited as proof of my consent.

*I hereby waive any evidentiary privilege that may exist between myself and any person or entity disclosing information pursuant to this release.*

_____
*{signature of parent}*

**SUBSCRIBED AND SWORN TO** before me, the undersigned notary public, on this _____day of _____, _____.

_____
Notary Public, State of Texas