



AUTHORIZATION TO RELEASE INFORMATION TO THE TARRANT COUNTY DOMESTIC REALTIIONS OFFICE

Name: First _____ Middle _____ Last _____
 Other Name(s) Used / Aliases _____
 Date of Birth: Month _____ Day _____ Year _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email Address: _____

I, AS NAMED AND IDENTIFIED ABOVE, AUTHORIZE THE FOLLOWING ENTITY:

Person/Organization Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Email Address: _____

TO DISCLOSE MY AND / OR MY CHILDREN'S INDIVIDUAL PROTECTED INFORMATION TO:

**Tarrant County Domestic Relations Office
 200 E. Weatherford, Family Law Center, 2nd Floor West
 Fort Worth, TX 76196-0258
fcs@tarrantcounty.com | Phone 817-884-1616 | Fax 817-212-7063**

AUTHORIZATION:

I, the undersigned, authorize the person or entity identified above to disclose all records pertaining to me, or my minor child/children, named herein, _____. Said person or entity is further authorized to confer with, consult with, and provide such information to a caseworker employed by the Tarrant County Domestic Relations Office. The information sought and released is directly relevant to the court-ordered investigation involving me and/or my child/children in Cause Number _____.

I acknowledge and expressly consent that this authorization permits the release of information that may otherwise be confidential, privileged, or sensitive in nature. Such information may include, but is not limited to, records or data relating to alcohol or chemical dependency (including illegal drug use), sexually transmitted diseases, HIV testing, AIDS-related conditions, psychiatric diagnoses or treatment, medical evaluations or testing performed on me or my child/children, medical records, criminal history records, counseling or therapeutic records, child abuse or neglect investigations, and educational records.

This authorization shall remain valid until revoked. I understand that I may revoke or withdraw this authorization at any time by delivering written notice of revocation to the records provider. Such revocation shall become effective only upon receipt by the records provider and shall not invalidate or affect any disclosures made prior to the provider's receipt of written notice. Absent earlier revocation, this authorization shall automatically expire one (1) year from the date of execution.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE DEEMED TO HAVE THE SAME FORCE AND EFFECT AS THE ORIGINAL.

SIGNED: _____ **DATE:** _____

PRINTED NAME: _____