Austin Psychotherapy Associates

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AUTHORIZATION TO RELEASE RECORDS

Patient name: ____ Birthdate: ________________________

- Records to be released **from**:

______________________________________ ______________________________________
Name Phone number

______________________________________ ______________________________________
Street address Fax number

____
City State Zip

- PLEASE CHECK INFORMATION REQUIRED TO BE RELEASED:

_____ Complete record _____ Progress notes only _____ Hospital/Discharge Summary

_____ Medication list _____ Lab reports only

- Records to be released **to**:

______________________________________ ______________________________________
Name Phone number

______________________________________ ______________________________________
Street address Fax number

____
City State Zip

I hereby authorize the source named above to send, as promptly as possible, medical records regarding my treatment to the above clinician. A fee for preparing and furnishing this information may be charged.

A photocopy of this release is to be considered as valid as the original.

______________________________ ______________________________ ___________
Signature of client Printed name Date

______________________________ ___________________________ ____________________ __________
Signature of parent/guardian/ representative Printed name Relationship Date