AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name:___________________________________

Date of Birth:__________/_________/__________

Street Address:_____________________________________

City/State/Zip:_____________________________________

I hereby authorize Family Psychiatry of The Woodlands, located at 8701 New Trails Drive, Suite 150, The Woodlands, TX 77381 to: (Please check one)

Release to:_____ Received from:____

Name of Person or Facility: ____

Street Address: ____

City, State, Zip: ____

Phone Number and Fax Number: ____

Please check all that apply

◻ History / Physical Exam	◻ Lab Results	◻ Consultations
◻ Discharge Summary	◻ Dr. Orders	◻ Progress Notes
◻ Psych Reports	◻ Verbal Communication	◻ All Records

For the purpose of: ____

This authorization covers patient care given from _______________ to ________________.

I understand that I may revoke this consent at any time, except to the extent that the action has been taken in reliance on it and that in any event this authorization shall expire upon my request.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient.

(FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42CFR, PART 2)

___________________________ ________________
Patient Signature *Date*

___________________________ ________________
Parent/Guardian Signature *Date*

___________________________ ________________
Witness Signature *Date*