Austin, TX
737-781-3028

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, authorize the release of medical records between **Shavon Mariah Social Services, P.A** at the above address, and to:

Name: _____

Street: _____

City, State, Zip:_____

Phone: _____

Fax: _____

The information contained therein pertains to:

- ❑ Psychiatric care
- ❑ Mental health evaluations
- ❑ Medical history and evaluation(s)
- ❑ Substance use and treatment
- ❑ Developmental and/or social history
- ❑ Educational records
- ❑ Progress notes and/or treatment plan
- ❑ Other: _____

The method(s) of release of information may include:

- ❑ Verbal communication
- ❑ Written communication

- ❑ Photocopies of record
- ❑ Facsimile transmission

The purpose of this release is:

- ❑ To communicate regarding treatment and coordination of care (e.g. with PCP or psychotherapist)
- ❑ For use by a third party (e.g. insurance company, lawyer)
- ❑ Other: _____

Information specifically excluded from this release if any: _____

I have read and understand the above document. This request is entirely voluntary. I understand that I may withdraw this authorization in writing to the above address at any time, except to the extent that action based on this authorization has already been taken. Copies of this authorization that show my signature are as valid as the original release signed by me. By signing this form, I authorize to release confidential health information.

Client Name: _____

Client Date of Birth: _____

Social Security Number: _____

Client Address: _____

Clients Phone: _____

Primary Holders Employers Name: _____

(The primary policy holder may be different from the client. The primary policy holder is the individual whose company is providing the insurance coverage, e.g., yourself, your spouse, your parent.)

First: Intake Date: _____

Client Signature: _____

(Patient or Legal Representative)

Shavon Mariah Social Services

Name and Credentials: _____

Intake Date: _____