Medical and Mental Health Clinic
1420 Valwood Parkway Ste. 170a
Carrollton, Texas 75006

Authorization to Release Health Information

Client Name: ___________________________ Date of Birth: ____________________________

I HEARBY AUTHORIZE Foundation Psychiatry, P.C. to release the following medical and clinical information:
- Medical, psychiatric, psychological and therapy evaluations and progress notes
- Laboratory Results
- Verbal/Written Communications
- Two Way Conversations
- Treatment Plans
- Exclude the following information: ____

For the purpose of: __ comprehensive case planning/continuity of care

__ other (specify) ________________________________

with the following:

Name: ______________________________________ Phone/Fax: __________________________

Other: ______________________________________ Phone/Fax: __________________________

Other: ______________________________________ Phone/Fax: __________________________

The above-mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules. I understand that this authorization to exchange information becomes effective when I sign this release and that I may revoke this authorization at any time by written notice to Foundation Psychiatry, P.C. However, such a revocation shall not affect any disclosures already made in reliance on your prior authorization. My refusal to sign this form will not affect my ability to receive care at Foundation Psychiatry, P.C. This authorization expires in 12 months and any further disclosure after that time will require signing a new form.

Client Signature: _______________________________ Date:_______________________

Signature of Parent/Legal Guardian if applicable:

Signature:_____________________________________ Date:________________________

Witnessed: ____________________________________ Date: ________________________