Austin Mind and Behavioral Health

AUSTIN MIND AND BEHAVIORAL HEALTH

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Date of birth: _____

Address of patient: _____

I authorize Austin Mind and Behavioral Health, its providers and its staff to use, obtain or disclose information about myself or for a minor (under the legal age of 18), for whom I am the legal guardian. The information may be disclosed to the following:

Name:_____
Name of Organization:_____
Address: _____
_____
Phone number: _____ Fax No: _____ Email: _____

I have checked all the information that may be included:

_____ Psychiatric evaluation
_____ Psychiatric Progress Notes
_____ Diagnosis and Treatment
_____ Substance Use diagnosis and Treatment
_____ Laboratory Tests or Imaging studies

Purpose of disclosure of information: _____

1. I fully understand and give this authorization, voluntarily without coercion.
2. I understand that a fax copy or a photocopy of this authorization will be considered as valid as the original.
3. I understand that this authorization is valid for one year from the date of signature.
4. I understand that I can revoke this authorization at any time by notifying Austin Mind and Behavioral Health.
5. I understand that I can request and receive a copy of this form.

With my signature below, I acknowledge that I have read and understand this authorization for release of information.

Signature of patient or Legal Guardian: _____

Relationship to patient: _____ Today's date: _____