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512-329-5575 Ph
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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient: _____ Ph: _____ D.O.B. _____

Address: _____
Street City/State Zip

I authorize the following release of medical information:

_____

_____

from and/or to: _____

Phone: _____ Fax: _____

Address: _____

to and/or from: _____

Phone: _____ Fax: _____

Address: _____

I understand that such disclosure will be made for the purpose of psychiatric treatment.

_____ _____
Date **Signature of patient**

_____
Witness

Print Form