Austin Family Mental Health

4005 Banister Lane, Suite 200C
Austin, Texas 78704
Phone: (512) 328-7222 Fax: (512) 328-8222

I hereby authorize **Austin Family Mental Health** located at 2700 Bee Cave Road, Suite 203, Austin, Texas 78746 to:

Release To and/or Obtain from

(Person/Entity Name) _____
(Address) _____
(City, State, Zip) _____
(Telephone) _____
(Fax) _____

Medical Records obtained during the course of treatment of:

(Patient Name) _____
(Date of Birth) _____
(Social Security Number) _____

The information to be disclosed is limited to:

- ☐ Entire Record
- ☐ Medication Record
- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Communication
- ☐ Billing/Financial Records
- ☐ Admission Notes
- ☐ Laboratory Data
- ☐ Physical Exam
- ☐ Psychological Testing
- ☐ Psychotherapy Notes
- ☐ Other (Specify) _____

The consent of disclosure is subject to revocation at any time except to the extent that the action has been taken in reliance thereon (i.e. information already disclosed). My signature means I have read this form and/or have had it read to me and explained in language that I can understand. I hereby release the above information from any legal liability resulting from the release of this information.

This consent of disclose will expire ninety (90) days after the termination of treatment, or as otherwise specified by date, event, or condition as follows, unless previously revoked by me:

Client Signature_____ Date_____
Signature of Parent/Guardian_____
Witness Signature_____ Date_____

TO THE RECEIVING PARTY OF THIS INFROMATION: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.