☆
Anxiety Treatment
Center of Austin

8701 Shoal Creek Blvd, Suite 404, Austin, Texas 78757
512-879-1836 www.anxietyaustin.com

Release of Information

I _____ hereby authorize the Anxiety Treatment Center of Austin, PLLC to:

☐ Release the following information to ☐ Obtain the following information from

Name: _____ Company: _____
Address: _____
Relationship to Patient: _____ Phone Number: _____

The information I would like released/obtained includes:

☐ Summary of Treatment
☐ Diagnostic Impressions
☐ Emergency Information
☐ Verbal Communication
☐ Other: _____
_____

For the purposes of:

☐ Treatment Planning
☐ Continuity of Care
☐ Emergency Contact
☐ Other: _____

Unless revoked by written request, this authorization shall remain in effect:

☐ Until _____ ☐ For one year from the date signed

I understand that the Anxiety Treatment Center of Austin, PLLC generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

Patient Signature: _____ Date: _____
Patient Name (Print): _____ Date of Birth: _____

If under 18 – Guardian Signature(s): _____ Date: _____
If under 18 – Guardian Name(s) (Print): _____

Witness/Clinician Signature: _____ Date: _____
Witness/Clinician Name (Print): _____