12151 W. Parmer Ln, Suite 202, Cedar Park, TX 78613 - Phone/Fax 512-593-7070

AUTHORIZATON FOR RELEASE OF INFORMATION

Many of our patients allow family members such as their spouse or parents to call and request medical or billing information. Due to HIPAA regulations, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical and/or billing information released to family members, you must complete and sign this form. This will only give consent to release the specific information to the person(s) listed.

I authorize Staats Psychiatric Services to release my medical and/or billing information to the following individual(s) as indicated:

1. Name: ________________________________ Relationship to Patient: _______________ Phone: ____________
   Psychiatric Care: ____________ Billing: _________________ Appointments: _____________________

2. Name: ________________________________ Relationship to Patient: _______________ Phone: ____________
   Psychiatric Care: ____________ Billing: _________________ Appointments: _____________________

Information specifically excluded from this release, if any: ____
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Unless otherwise specified, this release is valid for one year from the date of signature below. I have read and understand the above document. This request is entirely voluntary. I understand that I may withdraw this authorization in writing to the above address at any time, except to the extent that action based on this authorization has already been taken. Copies of this authorization, that show my signature, are as valid as the original release signed by me.

Patient Name: ____ DOB: ___________________________

Patient Signature: ____ Date: ___________________________