STAATS
PSYCHIATRIC SERVICES

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

AUTHORIZATON FOR RELEASE OF INFORMATION

I, _____, authorize the release of my own or _____'s medical records/information between Staats Psychiatric Services, at the above address, and the below Healthcare Provider or Other Entity:

Name: _____
Relationship: _____ Specialty: _____
Address: _____
Phone / Fax: _____

The information contained therein pertains to:

___ Psychiatric Care
___ Substance Abuse Treatment
___ HIV status and/or testing
___ Appointment / Attendance verification
___ Other: _____

The method(s) of release of information may include:

___ Verbal Communication
___ Facsimile Transmission
___ Photocopies of records(s)
___ Written Communication (including email)
___ Other: _____

The purpose of this release is:

___ To communicate regarding treatment & coordination of care
___ For use by a third party (i.e. insurance company, attorney, CPS, etc.)
___ Other: _____

Information specifically excluded from this release, if any: _____
_____

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: _____
Legal Guardian/Representative Name (Printed) : _____
Relationship: _____
Signed: _____ Date: _____
(Patient or Legal Guardian/Representative)