CINDY AUSTIN, MS, LPC
4500 Alamosa Drive
Austin, Texas 78759

(512) 422-1712
cindy@austinempowered.com
AustinEmpowered.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize *Cindy Austin, MS, LPC* to

_____ **Disclose to** _____ (Person/Entity)
_____ **Obtain from** _____ (Person/Entity)
_____ (Address)
_____ (City, State, Zip Code)
_____ (Phone Number)
_____ (Fax Number)

I understand that this authorization extends to all or any part of the records, which may include treatment for physical and mental illness, as well as chemical or alcohol dependency. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

_____

Print Patient Name **Date of Birth** **Date(s) of services if known**

Description of Information to be Released: (***Initial all that apply***)

____ Reason for referral ____ Client History ____ School Progress ____ Diagnostic Reports
____ Progress Notes ____ Treatment Summary ____ Treatment Prognosis ____ Psychological Tests
____ Discharge Summary ____ Billing/Financial Record ____ Mental Status Exam ____ Admission Notes
____ Court Information ____ History/Physical Exam
____ Other_____ ____ Verbal Communication with:
_____ Name
_____ Relationship

The purpose of the disclosure is for the following: (*Initial the appropriate category*)
Patient Request: ____ Continuity of Care ____ Personal Information ____ Court Involvement ____ School ____ Other:
Please explain_____

I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the release of information may no longer be protected by federal and state privacy regulations.

I desire this authorization to be in effect until _____. (Expiration Event/Day) I hereby release Cindy Austin, MS, LPC from all legal responsibilities or liability that may arise from disclosure of my medical or behavioral health records in reliance of this Authorization. I understand that I may revoke this Authorization by requesting a written revocation of authorization that can be obtained from Cindy Austin, MS, LPC. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the revocation.

_____
Date Patient Signature

_____
Date Parent/Guardian Signature

_____
Date Cindy Austin, MS, LPC