AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I hereby authorize Austin Therapy for Girls LLC to disclose the individually identifiable health information as described below, primarily verbal communication for treatment planning.
I understand that this authorization is voluntary and I may refuse to sign this authorization.
I further understand that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if I do not sign this form, federal and state law will prohibit Austin Therapy for Girls LLC from releasing records regarding treatment of me/my child to the designated Recipient. This release is primarily used for verbal communication unless noted.

Patient Name: _____ Date of Birth: _____

Specific ATFG Therapist: _____ Contact information:_____

- Psychiatric or mental health name/contact: _____
- Psychiatric contact email: _____#_____

Verbal communication

- Physician/ Other Helping Professional name: _____
- Physician/OHP email: _____ #_____

Verbal communication

- School name/contact: _____
- School email: _____#_____

Verbal communication

- Parent for purposes of billing: _____
- Phone number: _____Email_____

I, _____(print name), hereby consent to the exchange of clinical/medical/ records or other confidential information between ATFG and the following providers. The purpose for this release is for treatment team planning. This authorization can be revoked at any time by any party above and ATFG. I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

_____ _____
Parent/Client signature Date