Authorization Release of Information (Adult)

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: _____

- Psychiatrist/Psychologist: _____
- Psychiatrist/Psychologist email: _____
- Psychiatrist/Psychologist phone number: _____

- Physician/ Other Helping Professional name: _____
- Physician/OHP email: _____
- Physician/OHP phone number: _____

- Nutritionist/Therapist name: _____
- Therapist email: _____
- Therapist phone number: _____

- University name and contact: _____
- Contact email: _____
- Contact phone number: _____

- Caregiver name/relationship: _____
- Email/Phone number: _____

I, _____, 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.

_____ _____
Signature Date