**North Texas Child Psychiatry, PLLC**

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**Authorization for Release of Information**

**Patient Information:** Name DOB

Address Phone

**Psychiatrist Information:**

Name Phone: Fax:

**Therapist Information:**

Name: Phone: Fax:

**Medical Provider:**

Name: Phone: Fax:

**I, the undersigned patient or legal guardian, hereby authorize verbal\_\_\_and/or written\_\_\_ information to be shared between the listed health care providers.**

Information to be released:   
□ Medical Record □ Progress Notes □Treatment Planning □Psychological testing  
□Psychiatric Evaluation □H&P/Lab work □Psychosocial □Other   
□Discharge and Aftercare plan □Drug/Alcohol Abuse Treatment Records

Release of Information for the following purpose:

□Treatment/Consultation □Patient request □Billing/claims □Attorney □Notification of Admission □Other

Patients Rights:

* The information authorized for release may include information which may indicate the presence of (non)communicable disease, or relate to mental health, or drug, substance or alcohol abuse.
* Drug/Alcohol Abuse Treatment Records: this category of medical information/records is protected by Federal confidentially rules (42 CFR Part 2). The federal rules prohibit anyone receiving this information or records from making further releases unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol of drug abuse patient.
* Release: I release Faculty listed above, its employees and agents from any liability in connection with the use of disclosure of the information and records released to any party pursuant to the Authorization. Authorization may be revoked in writing, but prior disclosures will not be affected.

**Patient Authorization:**

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it ant that in any event, this consent shall expire twelve months from the date of the signature, unless another date is specified. I have read and understand the above information and give my authorization.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

or □I DO NOT give my authorization to release any information.