GRAMERCY SPECIALTY CLINIC

2211 S. Interstate 35, Ste 103 Austin, TX 78741 P: (512)766-3627 F: (512)777-2801

AUTHORIZATION TO RELEASE INFORMATION

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Gramercy Specialty Clinic to (check one):

\_\_\_\_\_ obtain records from the following person/entity:

\_\_\_\_\_ release records to the following person/entity:

Name of Person/Entity : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Person/Entify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gramercy Specialty Clinic shall release the following documents/information (check all that apply):

\_\_\_\_\_ Evaluation \_\_\_\_\_ Treatment Plan

\_\_\_\_\_ Progress Notes \_\_\_\_\_ Diagnosis

\_\_\_\_\_ Verbal Communication \_\_\_\_\_ Other (please specify documents/information to be released):

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The records are required for the purpose of (check one) : \_\_\_\_\_Continuity of Care \_\_\_\_\_ Other

I understand that my authorization will remain in effect for one year from the date of my signature and that the information will be handled confidentially in compliance with all applicable laws. I understand that I may see the information that is to be sent, and that I may revoke this authorization at any time by written, dated communication.

I have read and understand that nature of this release.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Client/Client’s Parent or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Client’s Parent or Legal Guardian Date