carefully

AUTHORIZATION TO REALSE INFORMATION

Client Name: _____ Client Date of Birth _____

I, the undersigned, herby authorize and request that CareFully _____ Release to _____ Secure from

_____

(Name of person and/or institution)

_____

(Address)

The following information may be included:
_____ Medical: Evaluation or treatment reports
_____ Psychological: Evaluation reports, test results, psychotherapy progress notes
_____ Substance and alcohol abuse information
_____ Other information as indicated:

I understand that the information is to be used for the following purpose(s):

_____

This authorization will automatically expire one year from the date of signature, except as specified

_____.

I understand that I may revoke this authorization by sending a written notice to CareFully at 600 Avenue J, Marble Falls, Texas. The revocation becomes effective when it is received and you are notified of the receipt. I understand that any information released prior to revocation and which was realized because of this authorization will not constitute a breach of confidentiality.

I further have the right to inspect the health information disclosed.

I understand that I am entitled to receive a copy of this authorization.

_____ _____ _____

(Signature of patient or legal guardian) (Relationship to client) (Date)