Specialty Clinic of Austin

☐ **NORTH** - Quarry Lake
☐ **SOUTH** - Southwest Medical Village

www.SpecialtyAustin.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:______________________________ Birth Date:______________

Address:____

City: ____________________TX Zip Code:__________ Phone:______________

☐ PLEASE SEND MY RECORDS TO SCOA

I give permission for the following two agencies/ persons to share my protected health information:

Provider:____________________

☐ **NORTH** 4515 Seton Center Pkwy, Ste 175
Austin, TX 78759
Ph 512-382-1933 **Fx** 512-777-4949

☐ **SOUTH** 5625 Eiger Road, Suite 215
Austin, TX 78735
Ph 512-610-7900 **Fx** 512-610-8901

☐ PLEASE SEND MY RECORDS FROM SCOA

Name: ______________________________

Relationship to Patient:______________________

Address:______________________________

City/State/Zip: __________________________

Phone: ______________________________

Fax:______________________________

☐ All Records ☐ Progress Notes ☐ Medication Information
☐ Psychiatric Evaluation ☐ Psychological Testing ☐ Lab Tests/Medical Imaging

☐ Other:____

I give special permission to share the following information (Please Initial):

_____ Psychotherapy Notes _____Alcohol/Drug Abuse

Approximate Dates of Service: ☐ Any

☐ From: ____________ To:____________

Purpose for Disclosure (Please Check):
☐ Continuity of Care ☐ At My Request ☐ Other:______________________

This authorization can be cancelled at any time by request, in writing, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. This office cannot control how the protected health information will be used by the agency/person who receives it under this authorization.

Unless cancelled or otherwise specified, this authorization will expire one year from date of signature.

Other Specified Expiration Date:______________

☐ I agree that my electronic signature on this application is binding and enforceable, as if I had signed a paper copy.

Patient or Guardian Signature: ______________________________ Date:____________

Printed Name: ____

Relationship to Patient (If Applicable): ______________________________

© Specialty Clinic of Austin