Nancy Stroud, L.C.S.W.

Licensed Clinical Social Worker

Office 281-693-1455

Texas State Board Of Social Work Examiners

AUTHORIZATION to USE/DISCLOSE MEDICAL INFORMATION

Patient Name: _____
Date of Birth: _____
I authorize _____ to:

(Initial) _____ Release information to: (Initial) _____ obtain information from:

_____
Name of Provider Address

Telephone: (_____) _____
Fax Number (_____) _____

Specifically, I authorize the exchange of the following confidential information by my Initial:
(Initial) _____ All Records in File (Initial) _____ Evaluations
(Initial) _____ Drug/Alcohol Information (Initial) _____ Legal Records
(Initial) _____ Telephone Consultation
(Initial) _____ Clinical information, excluding Psychotherapy Notes
(Initial) _____Other:_____

For the purpose of [ ] Treatment Coordination [ ] Continuity of care [ ] Insurance [ ] Legal review
[ ] Other: _____

I have reviewed and I understand this Authorization. By signing this Authorization, you are directing us to disclose your health information to another person or organization that may not have or obey the same obligations to protect privacy that we do under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for unauthorized re-disclosure and loss of protection under state and federal law.

This authorization will expire 180 days from the date of signing unless revoked earlier or otherwise indicated.

_____
Signature of patient or authorized representative Date

Witness Signature: _____