Suzanne H. Grantham, PMHNP
1101 S. Capital of Texas Hwy, Building A, Suite 200 Office: 512.617.6746
Austin, Texas 78746 Fax: 512.329.5522 / 512.387.8824

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: _____ Phone: _____ DOB: _____

Persons Authorized to Use or Disclose Information:	**Information May be Released Via:**
☐ Suzanne H. Grantham, PMHNP ☐ _____ (Other)	(Check all that apply) ☐ Pick up at office ☐ Email ☐ Phone ☐ Mail ☐ Fax
Persons to/from Whom Information May be Disclosed: Name: Address: City/State: Zip: Phone: Fax: Email:	**Expiration Date of Authorization:** This authorization is effective through / / Unless revoked earlier by the patient or the patient's personal representative.

INFORMATION TO BE USED OR DISCLOSED

☐ Entire Record ☐ Medication Records ☐ Lab Results ☐ Psychiatric Record
☐ Initial Evaluation ☐ MRI Results ☐ EEG Results ☐ Disability Assistance Request
☐ Progress Notes ☐ Treatment Plan ☐ Psychological Testing ☐ Other: _____
☐ **ALL DATES** ☐ **FROM DATE:** _____ **TO DATE:** _____

I also give special permission to release any information regarding items listed below:

☐ Psychiatric (Initial) _____ ☐ HIV Medical Info (Initial) _____ ☐ Substance Abuse (Initial) _____

PURPOSE OF DISCLOSURE

☐ Continuity of Care ☐ Patient/Guardian Request (fee applies) ☐ Disability Benefits (fee may apply)
☐ Attorney Request (fee applies) ☐ Other (fee applies): _____

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation to Suzanne H. Grantham, PMHNP's office. You should contact our Office Manager/Privacy Official to terminate this authorization.

POTENTIAL FOR RE-DISCLOSURE

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Suzanne H. Grantham, PMHNP's office discloses it to another party.

RIGHTS OF THE INDIVIDUAL

You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

EFFECT OF REFUSING AUTHORIZATION

If you refuse to sign this authorization, Suzanne H. Grantham, PMHNP will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including: treatment for enrollment, eligibility for benefits, etc.

Patient Signature Date Parent/Guardian Signature Date

Staff Member/Witness Signature Date Parent/Guardian Signature Date