STONEBRIAR PSYCHIATRIC SERVICES, PA

AUTHORIZATION FOR RELEASE OF INFORMATION

RECORDS REQUEST

Patient's name: _____

DOB: _____ SS #: _____

This will authorize:

David T. Tharp, M.D., M.Div. and / or
Stonebriar Psychiatric Services, PA and its employees
3550 Parkwood Blvd. Suite 705
Frisco, TX. 75034 FAX: 972-335-2434

To release to (give complete name, address and fax number): _____

_____

Initial here: _____ (to allow for an exchange of information between the above two parties).

The following information:

☒ Medical Information (to include HIV/AIDS information _____ Initial and drug & alcohol information ____ Initial

☐ Include the following additional information:

_____

_____

_____

☒ Counseling & Therapy information to include HIV/AIDS information ____ Initial and drug & alcohol information _____ Initial

For the purpose of (must be completed): _____

_____

AUTHORIZATION: I certify that this request was made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by notifying Stonebriar Psychiatric Services, PA in writing. I understand any request for revocation will not have any effect on any actions taken prior to its submission. I understand that if the entity authorized to receive the information is not a health care provider, the released information may not be protected by federal privacy regulations. This authorization will expire 180 days from the date of signature unless otherwise stated. I understand that this request will incur fees as follows: $25 which includes up to 20 pages PLUS $.50 per page exceeding 20 pages. This amount must be pre-paid.

_____ _____ _____

Signature of Patient (or Legal Representative) | Date | If Legal Representative, Relationship to Patient

_____ _____

Witness | Date