STONEBRIAR PSYCHIATRIC SERVICES, PA

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's complete name: ____

DOB: ________________________________ SS # ____________________________

This will authorize

Name/Phone: ____

Address: ____

Phone: ________________________________ Fax: ________________________________

To release to:

Stonebriar Psychiatric Services, P.A. and/or
David T. Tharp, M.D., M.Div.
3550 Parkwood Blvd. Suite 705
Frisco, TX. 75034

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

The following information:

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

☐ Only the following information (specify dates of service or condition):

____

____

____

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

For the purpose of: Continuity of care, coordination of treatment

____

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 may result in additional fees as outlined in the Office Policy.

______________________________	____________	______________________________
Signature of Patient (or Legal Representative)	Date	If Legal Representative, Relationship to Patient
______________________________	____________	
Witness	Date	

Revised 9/1/2011