C A T H Y E I S E N H O W E R , L P C

4111 Medical Parkway, Suite 201, Austin, TX 78756 512.827.7648
info@cathyeisenhowerlpc.com cathyeisenhowerlpc.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth:_____
Other names (if applicable): _____ SS#: _____

I hereby request and authorize **Cathy Eisenhower, LPC,** to ☐ release information to / ☐ obtain information from:

Name/Agency: _____

Address: _____

City, State: _____ **Zip:** _____

Phone: _____ **Fax:** _____

Email address: _____

Information to be released/obtained will be limited to:

☐ Assessment ☐ Medical Hx/Records ☐ Observation

☐ Treatment plan ☐ Educational testing/Records ☐ Consultation

☐ Progress Notes ☐ Psychological test(s) ☐ Other: _____

☐ Discharge Summary ☐ Psychiatric/psychological evaluation ☐ Other:_____

The purpose or need for such exchange of information:

☐ Coordination of Care ☐ Insurance Application ☐ Other: _____

☐ Exchange of Records ☐ Other: _____ ☐ Other: _____

I understand that this authorization can be revoked at any time, except to the extent that action has been taken in reliance upon it. Unless previously revoked, this authorization will expire at the termination of treatment, or on _____ (specified date). A copy of this authorization shall be considered valid.

_____ _____

Notice to Recipient of Information

This information has been disclosed from records, the confidentiality of which is protected by federal and/or state law. Further disclosure of this information is prohibited unless expressly permitted by the written consent of the person with authorization to do so, or as otherwise permitted and/or mandated by law.

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Signature of Patient Date

Parent/Guardian Signature Date

Cathy Eisenhower, LPC Date

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