

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