LARA MATTOX, Ph.D., PLLC

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AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name: _____ Birth Date: _____

I hereby authorize Lara Mattox, Ph.D., to have communication about the above-named patient with the following individual or agency:

_____

Individual/Agency Telephone

_____

Address Fax

Specifically, I authorize Dr. Mattox to:

☐ give the following information:
_____ Verbal communication
_____ Psychological test results and report
_____ Progress Notes
_____ Other: _____

☐ receive the following information:
_____ Verbal communication
_____ Psychological test results and report
_____ Medical Records
_____ Other: _____

I authorize release of this information until: ☐ specify date: _____ OR
☐ 12 months from today's date ☐ ongoing, unless consent is revoked in writing

My signature below indicates my understanding of and authorization and consent for the following:

1. This Authorization to Release Patient Information covers the release of the information that may already be contained in my records with Dr. Mattox, as well as information to be collected during the course of Dr. Mattox's work with the patient.
2. Use of this authorization form will reveal or imply that mental health services have been/are being provided to the patient.
3. This authorization is subject to my revocation at any time, except for information that may have already been released based on this authorization.
4. Revocation must be made in writing.
5. I have a right to receive a copy of this authorization.
6. A copy of this form is as valid as the original.

_____ _____

Printed name of person signing this authorization Relationship to Patient

_____ _____

Signature Date

_____ _____

Doctor's Signature Date