Lauren Gaspar, LCSW
Licensed Clinical Social Worker
4131 Spicewood Springs Road, Suite F1
Austin, TX 78759
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AUTHROIZATION FOR RELEASE OF INFORMATION

Authorization must be completed in full

I hereby authorize ***Lauren M. Gaspar, LCSW*** to
________ **Disclose to** ____ (Person/Entity)
________ **Obtain from** ____ (Person/Entity)
____ (Address)
____ (City, State, Zip Code)
____ (Phone Number)
____ (Fax Number)

my behavioral health information as described below. I understand that this authorization extends to all or any part of the records, which may include treatment for physical and mental illness, as well as chemical or alcohol dependency. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

____

Print Patient Name **Date of Birth** **Date(s) of service if known**

Description of Information to be Released: ***(Initial all that apply)***

____ Reason for referral ____ Client History ____ School Progress ____ Diagnostic Reports
____ Progress Notes ____ Treatment Summary ____ Treatment Prognosis ____ Psychological Tests
____ Discharge Summary ____ Billing/Financial Record ____ Mental Status Exam ____ Admission Notes
____ Court Information ____ History/Physical Exam (Including SANE Exam)
_____ Verbal Communication with:
____ Other ____________________________________ ____Name
____________________________________Relationship

The purpose of the disclosure is for the following: ***(Initial the appropriate category)***

Patient Request:
____ Continuity of Care ____ Personal Information ____ Court Involvement ____ School
____ Other: Please explain ____

I understand that if the recipient authorized to receive the information is not a health plan r health care provider, the release of information may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire 60 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _
____.
(Expiration event/Date)

I hereby release Lauren M. Gaspar from all legal responsibilities or liability that may arise from disclosure of my medical or behavioral health records in reliance of this Authorization.

I understand that I may revoke this Authorization by requesting a written revocation of authorization that can be obtained from Lauren M. Gaspar, LCSW. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the revocation.

____ ____
Date Patient Signature Date Parent/Guardian Signature

____
Date Lauren M. Gaspar, LCSW