Authorization Form
Watson Center for Psychotherapy
Release of information for Meggan Watson, LCSW
8901 Gaylord Suite 110
Houston, TX 77024
713.467.2240

This form when completed and signed by you authorizes me to exchange protected information from your clinical records to, from, or both, with the person you designate.
I authorize

Name _____
Address _____
Phone _____
Fax _____

(Check one)
[] To release and receive [] To release only [] To receive only

Protected information with/to/from

Watson Center for Psychotherapy
Meggan Watson, LCSW
8901 Gaylord Suite 110
Houston, TX 77024
Tel: 713.467.2240
Fax: 713-973-3902

I am requesting the release of this information for the following reasons: ![]
Coordination of care
[] **Other**: _____

[] This authorization shall remain in effect for one year after the signature date.
[] This authorization shall remain in effect until _____.
You have the right to revoke this authorization, in writing, at any time by sending written notification to my office address. However, you revocation will not be effective to the extent I have taken action in reliance on the authorization or if this authorization was obtained as a condition of insurance and the insurer has a legal right to contest a claim

Name of Patient:_____ DOB:_____
Name of Guardian:_____ Relationship:_____
Signature:_____ Date: _____