

# Cedar Creek Associates

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## Authorization for Release of Information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

I authorize \_\_\_\_\_ to

Release information to:

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone # (include area code)

\_\_\_\_\_  
Fax # (include area code)

I authorize \_\_\_\_\_ to

Release information to:

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone # (include area code)

\_\_\_\_\_  
Fax # (include area code)

PURPOSE OF THIS REQUEST: (circle one)  Healthcare  Insurance Coverage  Personal  Other

TYPES OF RECORDS AUTHORIZED:  Psychiatric/Psychological Evaluations and/or Treatment

Drug/Alcohol Evaluation and/or Treatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

Assessments  Progress Notes  Test Results: \_\_\_\_\_  Diagnostic Impression

Discharge Summary  Treatment Plans  Treatment Summary

Other: (please describe) \_\_\_\_\_

Periodic Use/Disclosure: I Authorize the periodic use or disclosure of the information described above to the person/provider/organization/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire:

One year from this date  Other \_\_\_\_\_

Signature of Client: \_\_\_\_\_

Date: \_\_\_\_\_