Kimberly McLaren, MD
2630 Exposition Blvd, Ste G02
Austin, Texas 78703
512-366-7275
www.mclarenpsychiatry.com

AUTHORIZATION TO RECEIVE OR TO RELEASE INFORMATION

Please be advised that your mental health records constitute privileged information that is protected by the laws of the State of Texas and that they may contain information that is protected under Federal Confidentiality Regulations. These records cannot be disclosed without your written consent unless otherwise provided for in the federal regulations as outlined in the Notice of Privacy Practices. Authorizing the release of information contained in your mental health records constitutes waiver of a privilege. You may revoke this consent through written notice, but it will not apply to action that has been taken prior to receipt of the revocation.

I, _____ request and authorize Dr. McLaren to
(Please print full name)

☐ Receive From ☐ Release To ☐ Discuss With

Name _____

Address _____

Phone/Fax _____

the following information from the record of my care and treatment (check all that apply):

- ○ Counseling and/or psychiatric record
- ○ Laboratory/assessment instrument
- ○ Conversations as needed to facilitate continuity of care
- ○ Other: _____

The purpose for this disclosure is: _____
Please note that the law prohibits further dissemination or use of these records for other purposes.

This authorization will remain in effect while I am under the care of Dr. McLaren unless otherwise specified here: _____

I specifically authorize the release of information pertaining to drug and alcohol abuse and/or HIV testing/test results if such is a part of the record. Release or transfer of the specified information to any person or entity not specified herein is prohibited by law.

My signature below indicates that I have read and fully understand the terms and conditions of this agreement. I do voluntarily agree to those terms and conditions contained herein.

Signature Date of Birth Today's Date