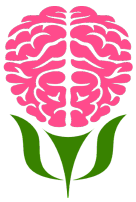
Patient Name: _____



AUSTIN PSYCHOLOGICAL
AND TESTING CENTER

2403 West Ben White Blvd Austin, Tx 78704
201 S. Lakeline Blvd. Ste 904 Cedar Park, Tx 78613

Telephone: 512-707-2782 Fax: 512-707-2783

Authorization to Release Information

I_____, authorize Austin Psychological Testing Center doctors and staff to release and exchange the following information. Please include a detailed description of which information you do want disclosed:

_____

_____

The above information should only be released to: Please write the name, phone number and fax number of the persons to whom the information is to be sent to.

_____

_____

_____

_____

I am requesting that my psychologist releases the above information for the following reason:

_____

_____

This authorization shall remain in effect until: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that if I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Print Name Date

_____

Patient or Guardian Signature