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REQUEST/AUTHORIZATION FOR RELEASE OF RECORDS

Client's Full Name: _____ DOB: _____

Information to be Released: _____

Purpose of Disclosure: The reason I am authorizing release is:

- My request
- Other (describe): _____

Person(s) Authorized to Make the Disclosure: _____

Person(s) Authorized to Receive the Disclosure: _____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient: _____

Signature of the Personal Representative: _____

Relationship to Patient if Personal Representative: _____

Date of Signature: _____