William Douglas McFarland LCSW
6304 Roseborough Drive
Austin, Texas 78747
512/705-1462 cell/office

Medical Release of Information

Client's Name:_____D.O.B._____Social Security Number:_____

By signing this form, I authorize you to release and or receive confidential health information, by releasing or receiving a copy of my medical information, or a summary or narrative of my protected health information, to/from the Primary Care Physician (PCP), Psychiatrist, or Entity listed below.

Please Check: _____Release my protected health information to the following person(s)/entity

_____Receive my protected health information from the following person(s)/entity

Name of PCP, Psychiatrist or entity to release or receive information to/from:

Name:_____

Street:_____

City:_____State:_____Zip:_____

Telephone:_____

The reasons or purposes for information needed are:_____

Limitations on the information you may release subject to this release form are as follows:_____

_____

If none, mark through and initial:_____

I understand that unless I request to revoke this authorization this request will remain in effect as long as the above client remains in treatment.

_____ _____
Signature of client, parent, guardian or legal representative Date

_____ _____
Doug McFarland LCSW Date