MERCY PSYCHOLOGY

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REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize: Wakiza Gámez, Ph.D. PO BOX 150309 AUSTIN TX 78715 832-418-7272

to release information from records about _____, born on _____ , and whose Social Security number is _____, for the following purpose(s):

❑ Further mental health evaluation, treatment, or care ❑ Rehabilitation program development or services
❑ Treatment planning ❑ Research ❑ Other:

These records concern the time between _____ and _____.

In the boxes below, the information to be disclosed is marked by an "X", the items not to be released have a line drawn through them and, page numbers are indicated when appropriate. Written dates indicate when those records were mailed to the requester.

❑ Intake and discharge summaries _____ ❑ Medical history and evaluation(s) _____
❑ Mental health evaluations _____ ❑ Developmental and/or social history _____
❑ Educational records _____ ❑ Progress notes, and treatment or closing summary _____
❑ Other: _____ _____

Please forward the records to:

Person or facility: _____

Address: _____

_____ Phone: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ❑ Do not release HIV-related information ❑ Do not release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____ _____ _____

Signature of client | Printed name | Date