BUTLER & ASSOCIATES
PSYCHOTHERAPY, PLLC

KASEY BUTLER, LCSW-S
Licensed Clinical Social Worker
4131 Spicewood Springs Rd., Ste. N3
Austin, TX 78759
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AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization must be completed in full

I hereby authorize *Kasey Butler, LCSW-S* to

_____ **Disclose to** _____ (Person/Entity)

_____ **Obtain from** _____ (Person/Entity)

_____ (Address)

_____ (City, State, Zip Code)

_____ (Phone Number)

_____ (Fax Number)

I understand that this authorization extends to all or any part of the records, which may include treatment for physical and mental illness, as well as chemical or alcohol dependency. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

_____

Print Patient Name **Date of Birth** **Date(s) of services if known**

Description of Information to be Released: (*Initial all that apply*)

____ Reason for referral ____ Client History ____ School Progress ____ Diagnostic Reports

____ Progress Notes ____ Treatment Summary ____ Treatment Prognosis ____ Psychological Tests

____ Discharge Summary ____ Billing/Financial Record ____ Mental Status Exam ____ Admission Notes

____ Court Information ____ History/Physical Exam (Including SANE Exam)

____Verbal Communication with:

____Other_____ _____ Name

_____ Relationship

The purpose of the disclosure is for the following: (*Initial the appropriate category*)

Patient Request:

____ Continuity of Care ____ Personal Information ____ Court Involvement ____ School

____ Other: Please explain_____

I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the release of information may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire 60 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.
(Expiration Event/Day)

I hereby release Kasey Butler, LCSW-S from all legal responsibilities or liability that may arise from disclosure of my medical or behavioral health records in reliance of this Authorization.

I understand that I may revoke this Authorization by requesting a written revocation of authorization that can be obtained from Kasey Butler, LCSW-S. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the revocation.

_____ _____

Date Patient Signature Date Parent/Guardian Signature

_____

Date Kasey Butler, LCSW-S