

**ADD Austin**  
**503 West 38<sup>th</sup> Street**  
**Austin, TX 78705**  
**512.459.5999**  
**512.459.6001 (fax)**

**Authorization to Release or Receive Information**

I authorize ADD Austin to release and/or receive:

- Psychological records, including test reports
- Psychiatric records
- Billing information
- Other: \_\_\_\_\_

This information should only be released to/from:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I am requesting ADD Austin to release/receive this information for the following reasons:

- at my request
- \_\_\_\_\_

This authorization shall remain in effect until:

- One year from the date below
- OR
- Until \_\_\_\_\_

You have the right to revoke this authorization, in writing, at any time by sending such written notification to ADD Austin at the above address. However, your revocation will not be effective to the extent that action has already been taken 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.

Your signature below indicates your understanding that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA Privacy Rule. In other words, ADD Austin has no control over how the recipient may use or disclose your information released under this Authorization.

\_\_\_\_\_  
Signature of Client or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Birth date

\_\_\_\_\_  
Authority of personal representative

\_\_\_\_\_  
Effective date of Authority