Monrovia Van Hoose, LCSW
Psychotherapist

Authorization to Release/Obtain Information

I, _____ , authorize Monrovia Van Hoose, LCSW
Name of person legally authorized to approve release.

to release / obtain from: _____
Circle one or both.

_____

_____
Name and address of individual(s) and/or organization releasing or receiving information.

the following information regarding _____ as checked:
Name of person whose information is being exchanged.

Note: Initials of authorizing individual are required next to each category checked.

_____ School (academic records, testing information, observations)

_____ Medical (medical history, medications, physical/lab reports, diagnosis)

_____ Psychological/Psychiatric (treatment notes, diagnosis, medications, admission/discharge)

_____ Other, as specified: _____

I understand that this release is only valid for the purpose stated above.

A photocopy of this authorization shall be considered as effective and valid as the original. Re-disclosure of information released by Monrovia Van Hoose, LCSW, without another authorized release form is prohibited by law.

I may cancel this authorization at any time (except retroactively), and if not canceled earlier, this authorization will automatically expire one year from the date next to my signature below.

Signed _____ Date _____
Signature of person authorized to approve release.

Therapist _____ Date _____
Signature of therapist.

5555 North Lamar Blvd. Ste. E • Austin, TX 78751 • {512} 529-3318 • mvh@monroviavanhoose.com