BioBehavioral Research of Austin

At

Specialty Clinic of Austin

Divyansu Patel, M.D.
Charles Sweet, M.D, MPH

Authorization for Release of Protected Health Information

Patient Name:_____ Birth Date:_____ Phone:_____

Address:_____City:_____ State:_____ Zip Code:_____

☐ Please Request My Records

I give permission for the following two agencies/persons to share my protected health information:

Divyansu Patel, M.D.
Charles Sweet, M.D. MPH

4515 Seton Pkwy, Ste 175 Austin, TX 78759
Ph: 512-382-6661 Fx: 512-582-9495
info@bbraustin.com

☐ Please Send My Records

Physician's Name:_____

Name of Practice:_____

Address:_____

City/State/Zip:_____

Phone:_____

Fax:_____

☐ All Records ☐ Progress Notes ☐ Medication Information ☐ Psychiatric Evaluation
☐ Psychological Testing ☐ Lab Tests/Medical Imaging ☐ Other:_____

I give special permission to share the following information (Please initial):

___Psychotherapy Notes

___Alcohol/Drug Abuse

☐ From:_____ To:_____

☐ ALL Dates

Purpose for Disclosure (Please Check):
☐ Continuity of Care ☐ At my Request ☐ Establish care ☐ Other:_____

This authorization can be cancelled at any time by request, in writing, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. This office cannot control how the protected health information will be used by the agency/person who receives it under this authorization.

Unless cancelled or otherwise specified, this authorization will expire one year from date of signature.

Other Specified Expiration Date:_____

Patient or Guardian Signature:_____ _____ Date:_____

Printed Name:_____

Relationship to Patient (If Applicable):_____