



Austin Travis County MHMR Center
P.O. Box 3548
Austin, Texas 78764-3548
(512) 447-4141, FAX (512) 445-7726

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES

You have the right to refuse to sign this authorization. Treatment, payment, or eligibility of benefits will not be conditional on signing this authorization. You have the right to inspect or copy protected health information to be disclosed. You will receive a copy of the signed authorization.

Client Name: _____ Client#: _____

Date of Birth: _____ Social Security#: _____

I authorize Austin Travis County MHMR to disclose the specified protected health information to _____
(Agency/Person)

Disclosed information limited to psychotherapy notes.

Psychotherapy notes dated from: _____ to: _____

Purpose/Need for Disclosure: _____

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

Expiration Date/Event: _____

Client Signature: _____ Date: _____

Personal Representative: _____ Relationship: _____