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Austin, TX 78746
(512) 327-7700
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Authorization to Release Confidential Records and Information

Name of Patient: _____ Date of Birth: _____

I hereby authorize the following person or facility:

to release information from records concerning me for the purpose of further evaluation and treatment to Dr. Erin Silvertooth.

This authorization covers ALL records and ALL dates.

This form also authorizes discussions of any aspects of this patient's case between the above-named person or facility and Dr. Erin Silvertooth. This specifically includes information transfer in both directions.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: Do not release (check).

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken.

Signature Date

Signature of parent/
Guardian/representative Printed Name Relationship Date