**Authorization for Release of Mental Health Information**

I hereby authorize Mandy Menzer, Psy.D. to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if I do not sign this form, federal and state law will prohibit Dr. Menzer from releasing her records of her treatment of me to the designated Recipient.

By accepting the records pursuant to this Authorization, the Recipient acknowledges that the protected health information covered by this release is confidential, privileged and protected by federal and state privacy statutes and regulations, and agrees that Dr. Menzer’s release of the individually identifiable health information will continue to be protected by federal and state privacy statutes and regulations.

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Print Patient Name Date of Birth

Description of information to be released: (check all that apply)

\_\_\_\_ Entire Record \_\_\_\_\_Psychotherapy Notes

\_\_\_\_\_ Summary of Treatment \_\_\_\_\_ Billing Record

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of the purpose of the use and/or disclosure, including any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The individually identifiable health information described herein shall be released to:

[INSERT NAME AND ADDRESS OF DESIGNATED RECIPIENT]

I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

**I further understand that I may revoke this authorization at any time by notifying Dr. Mandy Menzer in writing at 8700 Manchaca Road, Suite 402, Austin, Texas 78748.** I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation. This release will expire on \_\_\_\_\_\_\_\_\_\_\_ unless revoked earlier.

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Signature of Client or Client’s Representative Date

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Printed Name of Client