Robin May-Davis Psychiatry P.A.

2224 Walsh Tarlton Lane #110 Austin TX 78746
512-291-6370 ph 512-291-6507- fax
www.Robinmaydavismd.com

CONSENT FOR RELEASE AND COLLECTION OF INFORMATION:

Name of Patient:____ DOB:_____________________

I hereby authorize Robin May-Davis, M.D. to furnish health care information concerning my present illness or injury, including mental health, addiction, and HIV information, to person(s) or organization(s) listed below. I further authorize other person(s) or organization(s) listed below to furnish all health care information concerning my present illness or injury or pertinent past health care information to Robin May-Davis, M.D. Information may be exchanged in verbal or written form.

Name of person(s) or organization(s)	address	telephone number	fax number

I understand that such disclosure will be made for the purposes of (check all that apply):

- ☐ Continuity of care
- ☐ Treatment planning
- ☐ Diagnosis or treatment
- ☐ Patient history
- ☐ Other (specify) ____

Please include:
Evaluation Imaging Laboratory testing
Progress notes Other Assessments
Other __________________

I have had explained to me and fully understand this consent for release and collection of information. This consent for release and collection of information is subject to revocation at any time. Unless sooner revoked, this disclosure remains effective for one year from the date of signature. Records released or received are subject to state and federal laws applicable to confidentiality of medical records and mental health information. A copy of this document will have the same validity as the original.

____

SIGNATURE OF PATIENT (OR LEGAL REPRESENTATIVE) **PRINTED NAME** **DATE**