5910 Courtyard Dr. Suite 220
Austin Texas 78731
512-382-6359 **512-382-6368 fax**

I authorize: _____ John Abraham, DO _____ Michael Ross, MD

_____ Kelly Campbell, MD, MPH _____ Craig Russell, M.Ed., LPC

_____ Mark Viator, LCSW _____ Hayley Kimble, LCSW

_____ Hope VanDyk, LPC _____ Katie Copeland, LPC

_____ to release information from the record of

_____ to receive information from the individual/facility below regarding:

_____ _____
(patient's name) (date of birth)

____ released to
____ receiving from

_____
(individual/facility)

_____
(mailing address)

_____ _____
(phone) (fax)

This consent may be revoked at any time by sending written notification to Collaborative Care.

__ All __Laboratory __ Evaluations __ History/physical __School Records __ Verbal Report
__Psych Testing __Notes __ Mental Health Records __ Other:_____

_____ _____
__ Patient __ Parent __ Guardian (check one) Date