Live Oak Psychiatric and Family Practice, PLLC

1100 NW Loop 410, Suite 700
San Antonio, TX 78213
Phone (210) 441-6024: Fax (210) 783-8321

Release of Information

I hereby authorize: Live Oak Psychiatric and family Practice, PLLC

To: __ Release information to: Name: _____
__ Obtain information from: Address: _____
__ Exchange information with: _____
_____
Telephone: _____

The information requested or authorized for release or exchange pertains to:

__ Mental Health
__ Education
__ HIV/AIDS
__ Sexually transmitted diseases
__ Drug or alcohol abuse

__ Progress notes
__ Psychotherapy notes
__ Lab studies
__ Medical tests/studies
__ Psychological testing
__ Educational testing
__ Other: _____

Purpose or need for such disclosure: Continuing care, ongoing treatment, and/or coordination of services.
_____
_____

This authorization is valid for 1 year from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patients Name Date of Birth

_____ _____
Patients Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date