Whitney H. Mitchell, M.D.
Psychiatry and Psychotherapy
910 Gruene Road, Bldg 1
New Braunfels, TX 78130
Phone (830) 625-0600 • Fax (830) 625-0603

Authorization for Release of Medical Records

To: _____

_____

You are hereby authorized to release medical record information, either in photocopies or through personal review such as indicated below:

Name of patient: _____

Date of birth: _____ SSN: _____

Name and Address of Person or Organization to receive information:

Dr. Whitney H. Mitchell

910 Gruene Road, Bldg 1, New Braunfels, TX 78130

Fax (830) 625-0603

Purpose of Release: Continuation of Care

Dates of specific treatment period to be released: _____

Specific reports to be released:

- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Physician Progress Notes
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Other (specify): _____

Specific authorization for the release of the following information is given as indicated by patient:

- ☐ HIV Test Results
- ☐ Any documentation of AIDS diagnosis
- ☐ Drug and Alcohol abuse treatment records
- ☐ Psychiatric/Mental Health treatment records

I understand that this consent will automatically expire 180 days after the date of request unless medical records are requested by the primary insurance company at a later date. This consent is subject to revocation at any time, except that a disclosure made prior to the revocation or without knowledge of the revocation is not invalidated. You and the physician, physician's office, physician's staff are hereby released from legal responsibility or liability for the release of the records to the extent indicated and authorized herein.

A COPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

_____ _____ _____ _____

Signature of Patient Date Signature of Witness Date