5757 Flewellen Oaks Lane, Suite 304
Fulshear, TX 77441
(P) 713. 332.4388 (F) 281.644.0211

Release of Information

I hereby authorize:
- Nicole K. Stahl, M.D.
-

To:
- __ Release information to:
- __ Obtain information from:
- __ Exchange information with:

Name: ______________________________
Address: ______________________________
____
____
Telephone: ______________________________

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

- Mental Health Records
- Education/Educational testing
- Medical Records
- Lab studies
- Drug or alcohol abuse

This authorization is valid until ____________. I may cancel this authorization at any time 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. I understand that once my information has been released, the recipient might re-disclose it. Dr. Stahl has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

______________________________ ______________________
Patient's Name Date of Birth

______________________________ ______________________
Patient's Signature Date

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