

River Bend Counseling

145 Landa, New Braunfels, TX 78130
Phone: 830-515-8480 Fax: 877-310-5968

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Address _____ Parent/Guardian Name: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to
the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.