Lillian Buchanan, Ph.D.
Texas State License #81587
Travis Heights Blvd.
Austin, TX 78704
425-802-6466

Authorization to Use or Disclose Health Care Information

Client Name:________________________________ Date of Birth:____________________________

Previous Name (if any):____

You may use or disclose the following health care information (check one):

____ All health care information in my medical record

____ Health care information in my medical record relating to the follow treatment or condition:

____

____ Health care information in my medical record for the dates: ______________________________

____ Other: specify date(s):____

____ **This information may be disclosed by Lillian Buchanan, Ph.D. to**: ______________________

____ **This information may be disclosed to Lillian Buchanan, Ph.D. by:** ______________________

Name (or title) and organization: ____

Address and/or telephone: ____

City:_________________________ State:___________________ Zip:________________

Reason(s) for this authorization (check all that apply):

____ Continuity of services between providers ____ At my request

____ Other: ____

_________________________________ _________________________________ _______________

Signature Print Name Date

By typing my name above, I agree that the signature and initials will be the representation of my signature and initials for all purposes when I (or my agent) use them on documents - just the same as a pen-and-paper signature or initial.