Jill Racine, PhD
Licensed Clinical Psychologist

4601 Spicewood Springs Rd · Building 4, Suite 200 · Austin, TX 78759 · 512.467.1376 · drjillracine.com

Authorization to Release Confidential Records and Information

____ ______________________________
Client name Date of birth

I/We hereby authorize the person(s) or facility listed below to release any and all records relating to the above named individual to Jill Racine, PhD:

Person(s) or Facility: ____

Address: ____

Phone: _________________________________ Fax: _________________________________

This authorization covers ALL records and ALL dates. This form also authorizes discussions of any aspect of this patient's case between the above named person(s) or facility and Jill Racine, PhD. This includes information transfer in both directions.

I have had this form explained to me and I fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is fully voluntary. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken.

________________________________ ________________________________
Signature of patient/guardian/ or representative Date

________________________________ ________________________________
Printed name Relationship to client (if applicable)