# AUTHORIZATION TO RELEASE PROTECTED INFORMATION

This form authorizes the release of protected information:

1. **One-way** (check one) or **two-way** (check both):
   - [ ] FROM the Anxiety & Stress Clinic at the University of Texas at Austin
   - [ ] TO the Anxiety & Stress Clinic at the University of Texas at Austin

2. Individual or agency to provide and/or receive information (based on above selection)

   Address

3. **Reason for request:**
   - [ ] Treatment
   - [ ] Assessment
   - [ ] Coordinate Care
   - [ ] Referral
   - [ ] Other (please specify):

4. **Info to be provided or released:**
   - [ ] Summary
   - [ ] Full Clinical Record
   - [ ] Assessment Report (if applicable)
   - [ ] Other (please specify):

5. **Authorization Expires:**
   - [ ] When no longer an active client at the Anxiety & Stress Clinic
   - [ ] Other:

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Location: CLA Building; 305 E. 23rd St., 4th Floor, Austin, TX 78712
Deliveries: 305 E. 23rd St., Stop E9000, Austin, TX 78712
Phone: (512) 471-7694
Fax: (512) 471-7665
Email: anxietystressclinic@utexas.edu
I UNDERSTAND that:

• I may revoke this authorization at any time, but I must do so in writing and send my revocation to the Clinic Director at the address listed in the header above. The revocation will not be effective to the extent that the information has already been disclosed. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by applicable federal or state privacy rules.
• Records provided for purposes other than treatment may result in charges.

Client Signature: ___________________________    Date: ___________________

Witness Signature: ___________________________    Date: ___________________