PATHWAYS
SPECIALTY CLINIC
2219 Sawdust Rd #1004, The Woodlands TX 77380

Authorization to release Protected Health Information

I _____ (Patient or Parent/Legal Guardian), hereby Authorize Pathways Specialty Clinic providers to discuss or/share my treatment records and/or my minor child's _____ (Name of Minor Child) treatment records, with the following personnel and Institutions.
The persons to disclosure the information to are as follows:
Name: _____ Relation: _____
Name: _____ Relation: _____
Name of School: _____
Name of Therapist/Counselor: _____ Phone: _____
Name of Primary Care Physician: _____ Phone: _____

Type of Information to be released,

* All records ____ *Initial Psychiatric Evaluation ____ * Follow up Notes ____ *Diagnosis____

* Labs Test results ____ * Psychological testing results ____ * Medications Record ____

Additional Authorizations: * Urine Drug test results/Substance use _____

* Psychotherapy notes ___ * HIV status (if applicable) ____
Reason for this authorization: * Continuation of Care ___ * Other: _____

I understand that this authorization can be cancelled at any time by request, in writing, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. Your provider has no control over how the protected health information will be used by the agency/person who receives it under this authorization.

_____ _____
Patient/Guardian Signature Date
Relationship to patient (if applicable): _____

_____ _____
Witness Date