Stephen Dai, MD
4810B Spicewood Springs Road
Austin, Texas 78759
Phone (512)346-5796 Fax (512)346-8509

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name____ DOB __________________

Address ____

City _____________________________ Zip Code _____________ Phone _____________________

I give permission for the following two agencies/persons to share my protected health information:

Name:	Stephen Dai MD	Name:	______________________________
Address:	4810B Spicewood Springs Rd.	Address:	______________________________
City:	Austin	City:	______________________________
State/Zip:	Texas, 78759	State/Zip:	______________________________
Phone:	(512)346-5796	Phone:	______________________________
Fax:	(512)346-8509	Fax:	______________________________

All Records ___________ Psychological Testing _________________
Psychiatric Evaluation ___________ Progress Notes ______________________
Medication Information ___________ Lab Tests/Medical Imaging ____________
Other: ____

I give special permission to share the following information (Please Initial):

Psychotherapy Notes _________________________ Alcohol/Drug Abuse ________________________

Purpose for Disclosure (Please check):
Continuity of Care ___________
At My Request ___________
Other: ___________

Approximate Dates of Service:
Any ______ From: __________________________ To: ________________________

This authorization can be canceled at any time by request, in writing, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. This office cannot control how the protected health information will be used by the agency/person who receives it under this authorization. Unless canceled or otherwise specified, this authorization will expire one year from date of signature.

Patient Signature: ____ Date: ____________________

Printed Name: ____