



drvaldes.net

You have the right to refuse to sign this authorization. The provider will not withhold treatment, benefits, or payments processing if you refuse to sign this authorization. You will receive a copy of this signed authorization.

Records and Information Pertaining To: *(please PRINT clearly)*

Client's Name: _____

Last First Middle

Home Address: _____

Street City State Zip

Client's Date of Birth: _____
Month / day / year

I Authorize: Lourdes Valdes, Ph.D., PLLC
633 E. Fernhurst Dr., Suite #501
Katy, TX 77450
832-437-6260

☐ To release and receive records to/from
☐ To only release mental health/medical records to
If none of the above is checked, all apply.

Name of Recipient

Address

Phone

City _____ State _____ Zip _____

FAX

I authorize the source named above to send, as promptly as possible, the records listed below marked by an X or a ✓ in the boxes below. **(The items not to be released have a line drawn through them.)** Page numbers are indicated where appropriate.

☐ All mental health records

☐ Clinical/educational impressions and observations☐ Psychological evaluation(s) and test reports

☐ Academic or educational records and test reports

☐ Treatment plan and treatment summary☐ Admission and discharge summaries

☐ Other health information (please specify below)

OHI:

The requested health information is authorized for ☐ Treatment planning/coordination ☐ Referral/continuity of care
☐ At the request of the individual ☐ Other (please specify):

Note: If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.

Note: If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family.

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the organization or facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

Unless this authorization is revoked earlier it will expire on: _____
(date, event, or condition of expiration)

Signature of client 18 and older (or client's representative)

Date _____

Printed name of client (or client's representative)

Relationship to client