DIRECTIONS FOR COMPLETING OUR RELEASE OF INFORMATION FORM

PATIENT NAME: **DOB:**

Gilbert J. Custer, Jr., M.D.'s office is authorized to receive and/or disclose information from/to:

Name:

Address:

City/ST: Zip:

Phone: Fax:

Email:

Information may be released by:
(Check all that apply)

☒ Pick up at Office ☒ Email

Please include the recipients full name and address.
A valid fax number or email address is required if we are to fax or email records.

To request all records, check "Psychiatric Record" and "ALL DATES".

INFORMATION TO BE DISCLOSED:

☐ Genetic Test Results Only

☐ Attending Psychiatrist Statement (includes psychiatric diagnosis and current medications)

☐ **Psychiatric Record** (May include all progress notes, symptom scales, prescription history, lab results, and patient correspondence) ☐ **ALL DATES** - OR - ☐ **From Date:** **To Date:**

☒ Other:

Because we adhere to more stringent guidelines, we require th patient/guardian's handwritten initials and signature below be

By initialing below, I give special permission to release informatio

☒ **Psychiatric (Initial____)** ☐ Genetic Info (Initial_____) ☐ HIV/AID

**WE MUST HAVE YOUR INITIALS NEXT TO "PSYCHIATRIC"
AND
**WE MUST HAVE YOUR HANDWRITTEN SIGNATURE.
(For patients under 18, we must have the parent or guardian signature.

Patient Signature Date Parer

Staff Member / Witness Signature Date Staff Member / Witness Printed Name

Gilbert J. Custer, Jr., M.D.
1101 S. Capital of Texas Highway
Building A, Suite 200
Austin, TX 78746
Office: (512)327-3800
Fax: (855)884-8606

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Per Texas Medical Board's guidelines, we charge $25 for pages 1 – 20, and 50¢ per page thereafter for records where applicable.
Once we receive a completed written request and applicable records fees, we have 15 business days to respond under Texas law.

PATIENT NAME: **DOB:**

Gilbert J. Custer, Jr., M.D.'s office is authorized to receive and/or disclose information from/to:

Name: _____

Address: _____

City/ST: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Information may be released by:
(Check all that apply)

☒ Pick up at Office ☒ Email
☒ Mail ☒ Fax ☐ Phone

Expiration Date of Authorization:
This authorization is effective through ____/____/____ unless revoked or terminated earlier by the patient or the patient's personal representative.

INFORMATION TO BE DISCLOSED: ☐ LAB RESULTS ONLY ☐ LAST 3 YEARS LABS + VISIT NOTES

☐ Genetic Test Results Only ☐ Treatment Plan ☐ Medication History Only

☐ Attending Psychiatrist Statement (includes psychiatric diagnosis and current medications)

☐ **Psychiatric Record** (May include all progress notes, symptom scales, prescription history, lab results, and patient correspondence) ☐ **ALL DATES** - OR - ☐ **From Date:** _____ **To Date:** _____

☒ Other: _____

PURPOSE OF DISCLOSURE: ☒ Continuity of Care ☐ Government Disability Benefits ☐ Insurance (Fee Applies)

☐ School Accommodations (Fee applies) ☐ Legal Purposes (Fee applies) ☐ Personal Use (Fee applies)

☐ Employer Disability Benefits (fee applies) ☐ Other (fee applies): _____

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION: You may revoke or terminate this authorization by submitting a written revocation to our Office Manager (Privacy Official). **POTENTIAL FOR RE-DISCLOSURE:** Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Dr. Custer's Office discloses it to another party. **RIGHTS OF THE INDIVIDUAL:** You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization. **EFFECT OF REFUSING AUTHORIZATION:** If you refuse to sign this authorization, Dr. Custer will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others (ie: treatment for enrollment or eligibility for benefits, etc.)

Because we adhere to more stringent guidelines, we require this form completed in its entirety including the patient/guardian's handwritten initials and signature below before disclosing protected health information.

By initialing below, I give special permission to release information regarding: (select & initial all that apply)

☒ **Psychiatric (Initial_____)** ☐ Genetic Info (Initial_____) ☐ HIV/AIDS (Initial_____) ☐ Substance Abuse (Initial_____)

_____ Patient Signature Date

_____ Parent / Guardian Signature Date

_____ Staff Member / Witness Signature Date

_____ Staff Member / Witness Printed Name

For Office Use Only:
Copy given to patient on _____
Staff Members Initials: _____