Alamo Mental Health Group
Authorization for Release of Confidential Information
Information to be Sent to AMHG
4242 Medical Dr., Ste. 6300, San Antonio, TX. 78229
Phone: (210) 614-8400 Fax: (210) 614-8165

Patient Name _____ DOB:_____ SS#: _____

1. I authorize_____ to disclose the following health information about me:

   _____ All Information/Records _____ Progress Notes

   _____ Billing Records _____ Evaluation/Consultation Reports

   _____ Other _____

2. The information to be disclosed is from_____ to ____ present/_____ (dates).

3. This information may be disclosed to (please give name and address of recipient):

   _____

   Alamo Mental Health Group

   4242 Medical Dr., Ste 6300

   San Antonio, Texas 78230

4. This information may be disclosed for the purpose of:

   _____ Coordination of Care _____ Assistance/Support of Treatment

   _____ Other _____.

5. The information may be disclosed until (ending date) _____. If this date is left blank, the authorization will automatically expire one year from the date I sign below.

6. I understand that I may decline to give authorization and that declining authorization to release information will not affect my ability to obtain treatment, payment, or my eligibility for benefits from AMHG.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature if appropriate Relationship to Patient