5910 Courtyard Dr. Suite 220
Austin Texas 78731
512-382-6359 512-382-6368 fax

I authorize: ______ William C. Streusand, M.D. ______ John Abraham, D.O.

______ Abigail Riggs, RN, PMHNP ______ Craig Russell, M.Ed., LPC

______ Greer Swiatek, CRC, LPC ______ Mark Viator, LCSW

______ Hayley Kimble, LCSW ______ Michael Ross, MD

______ Mara Thornberg, LPC ______ Hope VanDyk, LPC

______ to release information from the record of

______ to receive information from the individual/facility below regarding:

____ ____________________________
(patient's name) (date of birth)

_____ released to
_____ receiving from

____
(individual/facility)

____
(mailing address)

____ ___________________________________
(phone) (fax)

This consent may be revoked at any time by sending written notification to Collaborative Care.

__ All __Laboratory __ Evaluations __ History/physical __School Records __ Verbal Report
__Psych Testing __Notes __ Mental Health Records __ Other:_________________________

____ ____________________________
__ Patient __ Parent __ Guardian (check one) Date