VAUGHN L. MANKEY, M.D.

Child, Adolescent, and Adult Psychiatry

1301 S. Capital of Texas Hwy, C-130 West Lake Hills, TX 78746
Phone: 512-522-3627 Fax: 512-732-0913

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____

Address: _____ Phone:_____

City:_____, TX Zip Code :_____

I give permission for the following two agencies/persons to share (both send and receive) my protected health information as indicated below:

Name: Vaughn L. Mankey, M.D.	Name: _____
Address: 1301 S. Capital of Texas Hwy	Address: _____
Building C, Suite 130	_____
West Lake Hills, TX 78746	_____
Phone: 512-522-3627	Phone: _____
Fax: 512-732-0913	Fax: _____

All Records	Progress Notes	Medication Information
Psychiatric Evaluation	Psychological Testing	Lab Tests/Imaging

Other_____

I give special permission to share the following: (initial)

___Psychotherapy Notes ____Alcohol/Drug Use

Approximate Dates of Service:

Any (or) From: _____to_____

VAUGHN L. MANKEY, M.D.
Child, Adolescent, and Adult Psychiatry

1301 S. Capital of Texas Hwy, C-130 West Lake Hills, TX 78746
Phone: 512-522-3627 Fax: 512-732-0913

Purpose for Disclosure (please check):

Continuity of Care At My Request Other_____

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

Other Specified Expiration Date: _____

Patient or Guardian Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient (if applicable): _____