Mark W. Matthews, PhD
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Authorization to Obtain, Release, and Exchange Clinical Information

Completing and signing this form shall authorize me to obtain, release, and exchange privileged, confidential, and protected information from your clinical record(s) to and/or from the person or entity you designate.

Patient Name: _____ Date of Birth: _____

My signature below authorizes Dr. Mark W. Matthews, a licensed clinical psychologist (TX 31431), to obtain, release, and exchange clinical information to and/or from

Name: _____

Address: _____

_____

_____

Telephone: _____

Fax: _____

I want Dr. Matthews to obtain, release, and/or exchange the following clinical information (as indicated by checkmarks below) contained within my patient/treatment/office records:

- ☐ Appointment dates
- ☐ Clinical interview information
- ☐ Progress/Therapy/Case notes
- ☐ Psychological assessment/test results
- ☐ Psychological testing/assessment raw data (e.g., protocols, transcripts, worksheets, etc.)
- ☐ Any written opinions regarding the referral question addressed in a psychological evaluation
- ☐ Other: _____

This authorization shall remain in effect until _____ or for 12 months from the date of signing, whichever is sooner.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Matthews' office address. I further understand that my revocation will not be effective to the extent that Dr. Matthews' has taken action in reliance upon this signed authorization.

_____ _____
Patient or Guardian Signature Date

_____ _____
Witness Signature Date