Timothy D. Sheehan III, M.D.
5656 Bee Caves Road Suite D-205
West Lake Hills, TX 78746

Authorization for Release of Protected Health Information

Patient Name: ____Birth Date: ________________

Address:____

City: _________________________ TX Zip Code: ______________ Phone:_____________________

I give permission for the following two agencies/persons to share my protected health information:

Name: Timothy D. Sheehan III, M.D.
Address: 5656 Bee Caves Road Suite D-205
City/State/Zip: West Lake Hills, TX 78746
Phone: (512) 710-1200
Fax: (512) 287-5521

Name: ____

Address: ____

City/State/Zip: ____

Phone: _____________________ Fax: ____________________

☐All Records ☐Psychological Testing ☐Psychiatric Evaluation ☐Progress Notes
☐Medication Information ☐Lab Tests/Medical Imaging
☐Other:____

I give special permission to share the following information (Please Initial):
____Psychotherapy Notes ____ Alcohol/Drug Abuse

Purpose for Disclosure (Please Check):
☐Continuity of Care ☐At My Request ☐Other:__________________________

Approximate Dates of Service:
☐Any ☐From: _____________ To: ______________
☐Other: ___________________

This authorization can be cancelled at any time by request, in writing, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. This office cannot control how the protected health information will be used 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 Signature: ____ Date: _____________________

Printed Name: ____