PEGGY KRUGER
TIETZ PH.D.
LICENSED PSYCHOLOGIST

Authorization to Release or Receive Information

I authorize Peggy Kruger Tietz, to release and/or receive:

_____ Psychological records, including test reports

_____ Psychiatric records

_____ Billing Information

_____ Other: _____

This information should only be release to/from:

Name: _____

Address: _____

Phone: _____ Fax _____

I am requesting Peggy Kruger Tietz, to release/receive this information for the following reasons:

_____ at my request _____

This authorization shall remain in effect until:

_____ one year from the date below or until _____

You have the right to revoke this authorization in writing, at any time by sending written notification to Peggy Kruger Tietz, at the above address. However, your revocation will not be effective to the extent that action has already been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim.

Your signature below indicates your understanding that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA Privacy Rule. In other words, Peggy Kruger Tietz has no control over how the recipient may use or disclose your information release under this Authorization.

_____ _____

Signature of Client or Personal Representative Date

_____ _____

Printed Name of Client Birth date

_____ _____

Authority of Personal Representative Effective date of Authority

1301 S. Capital of Texas Hwy, Bldg. C, Suite 130, Austin, TX 78746