



(Optional form. Fill out this form only if you are requesting medical records be sent to Mr. Fuller, or if you are authorizing Mr. Fuller to release info to other professionals for continuity of your care).

Medical Release Form

From/To Offices of Clifton Fuller, LCSW, LPC, LMFT

15303 Huebner, Bldg #10, San Antonio, TX 78248, 210-404-9001, fax 888-599-1976

Client name (printed) _____

DOB: _____ hereby authorize Clifton Fuller, LCSW, LPC, LMFT or his offices to:

() Disclose to () Obtain from

Group/Professional/Facility(s): _____

Address: _____

Telephone #: _____ Fax #: _____

Circle appropriate request (s): 1/Evaluation 2/Treatment Summary 3/Hospital/Discharge Summary 4/Testing 5/Progress Notes 6/Educational Records 7/Medical Notes/Information 8/Therapist files or 9/ANY & ALL information necessary for continuity of care

Records are regarding me (or my child your name or name of child): _____

(DOB of self/child) _____ while a patient between the dates of _____ and _____.

The purpose of the release of this data shall be:

1/further health care 2/treatment planning 3/educational planning

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records, information, implications of its release and is made voluntarily on my part.

I understand I may revoke this consent, in writing, at any time within thirty (30) days except to the extent that action based upon this consent has been taken. This consent will expire only upon written notice by person listed above.

Client Signature: _____ Date: _____

Client name printed: _____

Spouse/or Guardian Signature: _____ Date: _____

Spouse/or Guardian name printed: _____

Witness: _____ Date: _____

Witness name printed: _____

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