Mark Zentner, Ph.D.
Licensed Psychologist
8701 Shoal Creek #403
Austin, TX 78757
512-965-9895

Request and Authorization for Release of Information

I, _____, request and authorize:

Mark Zentner, Ph.D. 512-965-9895
8701 Shoal Creek #403
Austin, TX 78757

To release relevant information to and have relevant conversations with:

_____ _____
(Name) (Phone)

_____
(Address)

_____

This disclosure is made for the following purpose(s):

Furthermore, I authorize the above named individuals/entities to share information that is relevant to my treatment with Dr. Zentner.

I specifically authorize the release of information pertaining to drug/alcohol use and/or HIV testing results if such information is part of the record.

I make this request and authorization of my own free will. I understand that my mental health records constitute privileged information that is protected by the laws of the State of Texas. I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by providing written notice to Dr. Zentner and/or the above named individuals. I understand that this consent remains in effect until specifically revoked by me in writing.

_____ _____ _____
Signature Printed Name Date