

Mary Lee Foundation Rehabilitation Center

CONSENT FOR RELEASE OF INFORMATION

I _____ (*patient or legal guardian*), do hereby grant authorization for _____, to **release the following information to the Mary Lee Foundation**, 1339 Lamar Square Dr, Austin, TX 78704. This is for the purpose of providing rehabilitative services.

_____ Legal documents (guardianship, SSA correspondence, probation, and/or parole reports)

_____ Personal identification (picture ID card, SS card)

_____ Medicaid, Medicare, M.A.P. or private insurance card

_____ Neuropsychological evaluation

_____ Psychiatrist/Psychologist reports

_____ Medical reports/records

_____ Physical therapy reports/evaluations

_____ Speech therapy reports/evaluations

_____ Occupational therapy reports/evaluations

_____ Behavioral health reports/evaluations

_____ Previous treatment records

_____ Discharge summary

_____ Service authorization

_____ Other: _____

Client Signature

Date

Parent or Legal Guardian Signature (if applicable)

Date

Mary Lee Foundation Rehab Center Rep.

Date

Ph: (512) 443-5777

Fax: (512) 444-9949