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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT'S NAME: _____ BIRTHDATE: _____

I hereby give my permission for _____
to release any confidential information, verbal or written,
regarding the above-name individual to include:

Information to be released to:

I understand that the information obtained will be treated
in a professional and confidential manner, and will not be
re-disclosed to any other person or agency without the
written consent of the above-named person and/or parent or
guardian.

This consent expires ninety (90) days from the date of the
signature.

PATIENT'S SIGNATURE (if necessary) _____ DATE

PARENT OR GUARDIAN _____ DATE

WITNESS SIGNATURE _____ DATE