MELISSA MCNELLY, M.A., P.A., L.P.C

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AUTHORIZATION FOR RELEASE OF INFORMATION OR RECORDS

Name:	Date of Birth:
Address:	Telephone Number:
City, State, Zip	Alternate Phone Number:

This is an authorization for **MELISSA MCNELLY** to convey and receive from:

Regarding any medical, psychological, social, or academic information relating to services rendered to me at this practice.

****THIS RELEASE IS FOR THE PURPOSE OF COMMUNICATING WITH ANY OR ALL OF THE FOLLOWING****

	Primary Care Physician		School Personnel
	Medical Specialist		Transferring Records to Another Physician
	Insurance Company		Personal Use
	Employer		Other

Please include the following:

	Progress Notes		Psychological or Neuropsychological Test
	Psychological Evaluation		Other

Printed Name:_____ Relationship to Patient:_____

Signature:_____ Date:_____

Legal Witness:_____

*ARTICLE 4495B, SECTION 5.08(i) TEXAS REVISED CIVIL STATUS REQUIRES THAT AN AUTHORIZATION FOR RELAEASE OF INFORMATION OR RECORDS