CAROLINE C. BATENBURG, M.D.
Child, Adolescent and Adult Psychiatry

Date:_____

To:_____ Regarding:
_____ Patient's Name_____
_____ DOB _____

Dear _____,

Please disclose the following:

[ ] all medical records [ ] discharge summary
[ ] verbal communication [ ] lab work
[ ] written information regarding treatment [ ] psychological testing
[ ] other _____

To: Caroline C. Batenburg, M.D. Phone # 830-606-0955
189 E. Austin St., Ste. 105 Fax # 830-625-4956
New Braunfels, TX 78130

Consent for Dr. Batenburg to release the following to you:

[ ] all medical records [ ] discharge summary
[ ] verbal communication [ ] lab work
[ ] written information regarding treatment [ ] psychological testing
[ ] other _____

The reason for the disclosure is
[ ] continuation of care
[ ] disability determination
[ ] other _____

My medical records may include information regarding diagnosis and treatment of DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SUNDROME (AIDS), or PSYCHIATRIC DISORDERS. I understand that requested copies will be subject to a reasonable fee. I understand that I may revoke this permission only by giving written notice to Caroline C. Batenburg, M. D.

_____ Date _____
Signature of Patient/Parent or Guardian

_____ Date_____
Witness