Release of Information

I, ____, have provided a complete and up to date list of all of my current physicians in the list below along with their phone numbers and specialty. I am authorizing Texas Recovery Support and all of the physicians listed to consult and communicate freely regarding my progress, prescriptions and any issues that may affect my health, safety, recovery progress as deemed appropriate by Texas Recovery Support and/or the physicians I have listed below. I understand that this supports my continuity of care and may increase the quality of service I receive as a whole.

I understand that I do not have to sign this release and if I choose not to I may speak with my physician or contact my insurance company for alternate referrals. I also understand that admission into the Texas Recovery Support services requires a complete and up to date Release of Information.

PHYSICIAN	SPECIALTY	PHONE

____
Client's Name (PRINTED)

______________________________________ ________________
Client's Signature Date