AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION Mailing: 2730 S. Val Vista Dr. Ste. 146 Gilbert, AZ 85295

Office: 480-471-8560 Fax: 888-979-8197

Patient Name: ____ Date of Birth: ___________

Address: ____
Street Apt # City State Zip

SEND RECORDS TO/FROM

Name of person or Facility: ____

Address: ____
Street Suite # City State Zip

Phone Number :(_____)_______-___________ Fax Number:(______)________-____________

Specific description of the information to be disclosed:

____Demographics
____Medication Consent
____Psychiatric Evaluation
____Progress Notes
____Treatment Plan
____Psychological Testing
____Phone contact
____Billing reports
____Lab Report
____Discharge Summary
____Other:_______________
____
____Full medical record

Specific description of the purpose of the disclosure:

____Continued patient care
____Other (specify):______________________________
____Disclosure at patient request

I authorize the provider to use or disclose information related to: (must be initialed)

____Behavioral Health care/Psychiatric Care
____Insurance Coverage (COB)
____I consent to the release of information created within 12 months before/after the date this authorization was signed

I understand that the Clinic will not condition treatment on my signing this authorization. The Clinic will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I understand that I may revoke this authorization at any time, unless the disclosing party has already relied on my authorization to disclose health information. To revoke my authorization, I must submit a written request to Redemption Psychiatry. Unless I revoke this authorization earlier, it will expire one year from the date of signature. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person/organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

____ ________________________
Signature of patient Date

If you are not the patient, but are signing on behalf of the patient, please complete the following:

____ ___________________________________
Printed name Relationship to patient (**Legal guardian ONLY**)
Attach a copy of court documents if applicable.

____ ____
Signature Date