Valley Family Psychiatry, PLLC

9821 E. Bell Road, Suite #100
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Phone: (480) 939-3339
FAX: (480) 361-1919

RELEASE/OBTAIN OF INFORMATION AUTHORIZATION

Patient Name:__________________________________Date of Birth:__________________

I request and authorize Dr. Patel to release/obtain information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and /or medical records by means of mail, fax, or other electronic methods to:

Name of person/facility to receive information:__________________________________

If facility, then specify name of person:______________________________________

Address:____

City:__________________________________State:________Zip Code:________________

Phone #:________________________________FAX:_____________________________

This authorization is:
_____Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis/treatment)
_____Limited to the following medical information:____________________________________

Please initial to specifically authorize the use and/or disclosure of:
_____Psychiatric/Mental Health
_____Drug/Alcohol/Substance Abuse
_____Tests for Antibodies to HIV
_____HIV Diagnosis/Treatment

Specify the date or time period for information selected above:________________________

Purpose(s) of this use/disclosure:
_____Continuity of care or discharge planning
_____At the request of patient/patient representative
_____Other (state reason)____

Unless otherwise revoked, this authorization expires: _____________________________(date or event)
If no date is indicated, this authorization will expire 12 months after the date of signing of this form.

-I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Dr. Patel
-I understand that Dr. Patel may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.
-I understand that if I authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal privacy regulations.
-I understand I am entitled to receive a copy of this Authorization.

Patient's/Authorized Representative's Signature:______________________________________
Print Name:____Date:___________________
Relationship/authority (if signed by authorized representative):__________________________