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IF MORE THAN 30 PAGES PLEASE MAIL OR CALL FOR APPROVAL

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:	**Patient DOB:**
Patient Address:	
City, State, Zip:	**Phone Number:**	**Patient Social Security:**

Information Being Released: ☐ **To** ☐ **From**

Office/Physician Name:	**Office/Physician Name:**
Address:	**Address:**
City, State, Zip:	**City, State, Zip:**
Phone: **Fax:**	**Phone:** **Fax:**

Information Being Released: ☐ **To** ☐ **From**

Information to be released:

☐ All Health Information
☐ Information related to:_____
☐ Information covering the treatment period:
_____
☐ Other: _____

Reason for Disclosure:

☐ Changing Physicians
☐ Continuation of Care
☐ Workers Compensation
☐ Legal
☐ Other: _____

I understand that this health information may include HIV-related information and/or information relating to the diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing information relating to:
◯ Substance abuse (inc: alcohol/Drug abuse) ◯ Mental Health ◯ Psychotherapy Notes ◯ HIV related information (inc: aids related testing).
The confidentiality of this record is required under the ariz. rev. stat § 36-661, ariz. rev. stat § 36-664, ariz. rev. stat § 20-448.01©, ariz. rev. stat § 20-448-01€, ariz. rev. stat § 36-507 & ariz. rev. stat § 36-509. All of these statutes can be found on the Arizona Legislator government website. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes. By signing I understand I am authorizing the release of the above stated records, separate from my general healthcare information.

_____ _____
Patient Signature Date

_____ _____
Legally Authorized Representative/Guardian Relationship

By signing below, I understand that this authorization will expire one year from the date the release is signed. A photocopy of this form will be considered as valid as the original. I understand that I may revoke this authorization at any time in writing and this authorization will cease to be effective as of the date notified. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. However, state and federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information, HIV/AIDS related information, and psychiatric/mental health information. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

_____ _____
Patient Signature Date

_____ _____
Legally Authorized Representative/Guardian Relationship