Desert Counseling & Recovery Services, PLLC
Release of Information Authorization Form

This form, when completed and signed by you, authorizes Desert Counseling & Recovery Services, PLLC to release and/or request protected health information from your clinical record to the person you designate.

Client/Patient Name: _____ Date of Birth: _____

Address: _____ City: _____State: _____ Zip Code: _____

Phone #: _____

Name of individual requesting information: _____

I authorize Desert Counseling & Recovery Services, PLLC to release by fax (928-259-2501) - Please initial this section where appropriate:

❍ Psychotherapy Notes _____

❍ Telephone Contact/Consultation _____

❍ Psychological Exam and/or Testing Results _____

❍ other (Please be specific and detailed about your request below: _____

❍ Treatment Summary _____

❍ Medical Record _____

This information should only be _____ exchanged with, _____ released to, and/or _____ obtained from

Name of person releasing information, party, or agency: _____

Address City State/ Zip Code: _____
Telephone Number Fax Number Email Address: _____

This authorization shall remain in effect until _____ or one year from the date signed.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Desert Counseling & Recovery Services, PLLC. However, your revocation will not be effective to the extent that Desert Counseling & Recovery Services has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Desert Counseling & Recovery Services personnel generally may not condition counseling services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that any release made prior to my revocation, in compliance with this authorization, shall not constitute a breach of my rights to confidentiality.

X_____ **X**_____ **X**_____
Printed Name **Signature of Self, Parent, or Guardian** **Date signed**

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided