

Ponderosa Counseling of Arizona  
Release of Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the mutual exchange of information between:  
(name of patient or guardian)

Deb Collins, PMHNP-BC, RXN  
1745 Rustic Timbers Lane, Suite G-2 · Prescott, AZ 86303  
Phone: 720-542-3487 Fax: 928-379-5083

and

\_\_\_\_\_  
(name of hospital, physician, school, teacher, etc.)

\_\_\_\_\_  
(address including city, state, and zip code)

\_\_\_\_\_  
(phone number)

\_\_\_\_\_  
(fax number)

I understand that information to be released for the purpose of psychiatric evaluation and ongoing treatment may include information regarding the following condition(s):

- Psychiatric Conditions, Psychological Testing, Progress Notes, Medications Prescribed
- Assessment including Diagnosis - Treatment Summary, Recommendations, Consultation
- Drug and/or Alcohol Abuse
- Medical/Educational Information
- HIV (Human Immunodeficiency Virus)/AIDS(Acquired Immunodeficiency Syndrome)

I understand that I may revoke this consent to release medical information at any time by giving written notice to Ponderosa Counseling Center except to the extent that action has already been taken to comply with it. Without such revocation, this consent is valid until treatment with Ponderosa Counseling Center ends.

I release Ponderosa Counseling Center from all legal responsibility and liability for the information released according to the terms of this written consent. I understand that there is the potential for this protected health information to be re-disclosed by the recipient and thus no longer protected under the HIPAA privacy rule.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(if 15 years or older)

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_