08 ROI General

Cactus Garden Mental Health Services, LLC.
7165 E. University Drive
Building 14, Suite 155
Mesa, AZ, 85207
Phone: (480)-913-5872
Fax Number: (602)-848-3105
Email: Frontoffice@cactusgardenmhs.com

This document gives Cactus Garden Mental Health Services, LLC permission to communicate with the designated individual(s), person(s), entity(ies), and/or organization(s) for the purposes of care coordination and continuity of care. If you do not wish for us to communicate with the specified individual(s), person(s), entity(ies), and/or organization(s), you may disregard this form.

Authorization to RELEASE, OBTAIN, and DISCUSS Confidential Records and Information

Printed Name of Patient: *

Patient's Date of Birth: *

Current Phone Number *

I understand that the information released, obtained and discussed will include the following, unless otherwise specified in the corresponding sections below: Complete medical record, including, but not limited to medical and psychiatric evaluations, consultation notes, medical and psychiatric progress notes, laboratory and diagnostic reports, and financial information. Information obtained may include sensitive personal health information, including, but not limited to, HIV/AIDS status, substance use history, and/or psychotherapy progress notes. *

☐ Yes ☐ No

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Time frame of records and information to be released, obtained and/or discussed will include ALL AVAILABLE unless I specify otherwise in the space to the right of this statement.

Because I believe it is in my/our best interest for my care, I authorize Cactus Garden Mental Health Services, LLC to RELEASE and DISCUSS the personal health information in my medical record with the individual(s), person(s), entity(ies), and/or organization(s) listed on this form.

☐ Yes ☐ No

**If you selected YES to the above question, please leave this next question blank.*

I authorize all of the above information to be RELEASED and DISCUSSED, except for the following:

☐ HIV/AIDS related information. ☐ Substance use related information. ☐ Psychotherapy progress notes.
☐ Laboratory reports (blood tests, etc.) ☐ Diagnostic imaging reports (i.e. EKG, MRI, CT scan, etc.).

Similarly, I authorize Cactus Garden Mental Health Services to OBTAIN and DISCUSS the protected health information listed on this form with the individual(s), person(s), entity(ies), and/or organization(s) specified below. *

☐ Yes ☐ No

**If you selected YES to the above question, please leave this next question blank.*

I authorize all of the above information to be OBTAINED and DISCUSSED, except for the following:

☐ HIV/AIDS related information. ☐ Substance use related information. ☐ Psychotherapy progress notes.
☐ Laboratory reports (blood tests, etc.) ☐ Diagnostic reports (i.e. EKG, MRI, etc.).

Individual(s), person(s), entity(ies), and/or organization(s)

Name of individual(s), entity(ies), person(s), and/or organization(s) with whom to release, receive, and/or discuss protected health information: *

Relationship: *

Cactus Garden Mental Health Services LLC
7165 E University Dr., Building 14, Suite 155
Mesa, Arizona, US - 85207

Address: *

Phone: *

Fax number:

Email:

Information may be released to other phone numbers, email addresses, fax numbers, or addresses associated with the organization(s), individual(s), or entity(s) not listed on this form.

I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to Cactus Garden Mental Health Services, LLC, except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in 1 year after signing. I have a right to inspect a copy of the health information to be released. If I do not sign this authorization, the institution named above will not release my health information. Cactus Garden Mental Health Services, LLC will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. I authorize the release and/or discussion of information to be conducted over telephone, email, text message, video chat and/or face to face, and/or faxes. My consent is fully voluntary.

I understand that this information may include protected health information concerning drug/alcohol abuse, mental health, and HIV/AIDS treatment unless specified in the designated responses above to the corresponding question.

Patient Name: *

Name of Parent/Guardian if applicable:

Signature of Patient (if over 18) or Parent/Guardian (if applicable): *

Date: *

Redisclosure: Notice is hereby given to the patient or legal representative signing this Authorization that Cactus Garden Mental Health Services, LLC cannot guarantee that the recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.