

**Biltmore Psychiatric Group**  
8687 East Via de Ventura Suite 305 Scottsdale, AZ 85258  
Phone (602) 843-0035 • Fax (602) 843-8963

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS  
AND/OR PROTECTED MENTAL HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize the release of general medical information, psychological/psychiatric information - including alcohol/drug abuse/addiction or HIV information - from my health records in accordance with Arizona State Statutes and Federal Administration Rules and Regulations.

Release to \_\_\_\_\_ or \_\_\_\_\_ Release from \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Information to be released: (NOTE: only records created by the practitioner named above during the course of treatment can be released under this authorization)

- |   |  |
|---|--|
| <input type="checkbox"/> Initial Psychiatric Evaluation | <input type="checkbox"/> Emergency Department Records              |
| <input type="checkbox"/> Office Progress Notes          | <input type="checkbox"/> Neuropsychological Evaluations            |
| <input type="checkbox"/> Laboratory Reports             | <input type="checkbox"/> All Hospital Records                      |
| <input type="checkbox"/> Imaging Reports                | <input type="checkbox"/> All Psychiatric and Psychological Records |
| <input type="checkbox"/> Medication Records             | <input type="checkbox"/> Personal Communication                    |
| <input type="checkbox"/> Billing Records                | <input type="checkbox"/> Other _____                               |
| <input type="checkbox"/> Discharge Summary              | <input type="checkbox"/> Information to be Withheld _____          |

Purpose for Disclosure  
 Continued Treatment       Disability Evaluation       Other: \_\_\_\_\_

Notice of Prohibition on Re-disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization. I understand that I have the right to refuse to sign this authorization and that the practice named above is released from all legal liability that may arise from the release of the information requested. Consent is subject to revocation at any time except to the extent that certain action based on this content has already been taken. Photocopies or similar reproductions may be substituted for the original authorization.

This consent will expire upon discharge from this provider or on: \_\_\_\_\_

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Phone: \_\_\_\_\_