BILTMORE PSYCHIATRIC GROUP
6245 N 24th PARKWAY, SUITE 203, PHOENIX, AZ 85016
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)

☐ Initial Psychiatric Evaluation
☐ Office Progress Notes
☐ Lab Results/X-ray Studies/ MRI Reports
☐ Medication Records
☐ Personal Communication
☐ Other

☐ 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 confidentially 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: _____