The ARIZONA SCHWARTZ GROUP

Consent to Release Information

Date: _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I, _____, hereby authorize **Dr. Marc Schwartz, DO** (The Arizona Schwartz Group, PC) to:☐ (send) ☐ (receive) the following information marked below ☐ (to) ☐ (from)

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

- ☐ Academic testing results
- ☐ Behavior programs
- ☐ Progress reports
- ☐ Intelligence testing results
- ☐ Medical records/reports
- ☐ Personality profiles
- ☐ Psychological reports
- ☐ Phone contact
- ☐ Other, specify_____
- ☐ Psychological testing results
- ☐ Service plans
- ☐ Summary reports
- ☐ Vocational testing results
- ☐ Entire record, except progress notes
- ☐ Behavioral and Emotional Scales
- ☐ Laboratory Tests
- ☐ All information, all charts, all communication

The above information will be used for the following purposes:

- ☐ Planning appropriate treatment or program
- ☐ Continuing appropriate treatment or program
- ☐ Determining eligibility for benefits or program
- ☐ Case review ____ Updating files
- ☐ Other (specify) _____

10165 N 92nd St, Suite 101, Scottsdale AZ 85258
T 480-899-4077 F 866-831-1158
www.azSchwartzGroup.com

OVER →

The ARIZONA SCHWARTZ GROUP

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered
by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: ☐ Self ☐ Parent/legal guardian ☐ Personal representative
☐ Other (describe)_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: ____/____/_____

Parent/guardian/personal representative (if applicable)

Signature: _____ Date: ____/____/_____

Witness (if client is unable to sign)

Signature: _____ Date: ____/____/_____

Provider Signature _____ Date: ____/____/_____

Dr. Marc Schwartz, DO

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