Arizona Behavioral Health Specialists, LLC
7330 N 16th St. Suite A120
Phoenix, AZ 85020
602-997-6635
FAX: 602-997-6642

Authorization for Release or Receipt of Information

Patient's Name:_____

Social Security #:_____ ***DOB:***_____ ***Date:***_____

This will authorize: (Name, Complete Address and Phone)

Name _____

Address _____

_____

Phone _____ ***Fax*** _____

To ☐ ***release*** ☐ ***receive***
Any & all medical records, reports, written consultations, patient records, test records & reports, psychiatric, psychological, behavioral health, substance abuse or alcohol records including treatment records. Authorized is medical information that may include AIDS/HIV & other Communicable Diseases.

☐ ***to*** ☐ ***from:***
Arizona Behavioral Health Specialists, LLC
7330 N 16th St. Suite A120
Phoenix, AZ 85020
602-997-6635 FAX: 602-997-6642

☐ ***Celia Drake, Ph.D., PC***
☐ ***Owen Golden, Jr., L.C.S.W.***
☐ ***Sean McDevitt, Ph.D.***
☐ ***Lia Roley, Psy.D***
☐ ***Deborah Lewis, Ph.D.***

Information to Be: ☐ *Released* ☐ *Received as Follows:*
☐ *Histories & Physicals*
☐ *Reports of Psychological Testing*
☐ *Office Notes*
☐ *Verbal and Written Exchange of Information*
☐ *Psychological Testing Raw Data*
☐ *Hospital Discharge Summary*
☐ *Summary of Treatment Records*
☐ *Other*

Purpose of Release:
☐ *Continued Treatment*
☐ *Psychological/Neuropsychological Evaluation*
☐ *Other*_____

I ***understand that I have the right to refuse to sign this authorization. I understand I have the right to get a copy of this authorization. I understand that cancellation or modification of this authorization needs to be in writing. I understand that I have the right to revoke this authorization at anytime unless action on this authorization has already been taken. I understand such revocation must be in writing.***
I understand that information used or disclosed pursuant to this authorization may be subject to re-discloser by recipient and may no longer be protected by the HIPPA Privacy Rule.

This authorization will remain valid until _____***.***

_____ _____
(Patient / Guardian Signature) *(Date)*