

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

**Authorization for Release or Receipt of Information**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**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 16<sup>th</sup> 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.*

**Information to Be:**  Released  Received as Follows:

- |  |  |
|--|--|
| <input type="checkbox"/> <i>Histories &amp; Physicals</i>                  | <input type="checkbox"/> <i>Psychological Testing Raw Data</i> |
| <input type="checkbox"/> <i>Reports of Psychological Testing</i>           | <input type="checkbox"/> <i>Hospital Discharge Summary</i>     |
| <input type="checkbox"/> <i>Office Notes</i>                               | <input type="checkbox"/> <i>Summary of Treatment Records</i>   |
| <input type="checkbox"/> <i>Verbal and Written Exchange of Information</i> | <input type="checkbox"/> <i>Other</i>                          |

**Purpose of Release:**

- |   |   |
|---|---|
| <input type="checkbox"/> <i>Continued Treatment</i>                         | <input type="checkbox"/> <i>Other</i> _____ |
| <input type="checkbox"/> <i>Psychological/Neuropsychological Evaluation</i> |   |

***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-disclosure by recipient and may no longer be protected by the HIPPA Privacy Rule.***

**This authorization will remain valid until** \_\_\_\_\_.

\_\_\_\_\_  
(Patient / Guardian Signature)

\_\_\_\_\_  
(Date)