

Arizona Behavioral Health Specialists, LLC
10000 North 31st Avenue C-202
Phoenix, AZ 85051
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
10000 North 31st Avenue Suite C-202
Phoenix, AZ 85051 602-997-6635 FAX: 602-997-6642*

- Celia Drake, Ph.D., PC
- Owen Golden, Jr., L.C.S.W.
- Sean McDevitt, Ph.D.
- Mary Nowlin, D.O.
- Lia Roley, Psy.D
- Amy Smith, M.D.

Information to Be: Released Received as Follows:

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

Purpose of Release:

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

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)