



AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____
Phone: Home) _____ **Phone: Cell)** _____
Address: _____ **City/State/Zip:** _____

Please Note: Retrieval and Copy Fees Will Be Charged For Medical Records

Above listed client authorizes the following healthcare facility to make record disclosure:

Desert View Counseling & Consulting, Inc. **OR;** _____
 13260 N 94th Dr, Ste. 100
 Peoria, AZ 85381

The purpose of disclosure is: Collaboration of Treatment Care Change of Insurance or Provider Referral Other _____	Dates and Type of information to disclose: All Dates of medical records Dates Other; TO _____ From _____ Specific Information Requested: _____
Information Released (check one of the following): <input type="checkbox"/> Verbal Only <input type="checkbox"/> Written Only <input type="checkbox"/> Both Verbal and Written	

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

Authorized Recipient (to whom the information will be provided):

Release To: _____
Address: _____
City, State, Zip: _____
Fax: _____ **Phone:** _____

Records to be released: <input type="checkbox"/> Please mail records to address provided for recipient <input type="checkbox"/> Please have records available for pickup at front office	DVCC Office Use Only: DVCC personnel signature: _____ Date Records Provided: _____
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I understand that signing this authorization is voluntary. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT, and CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION.** I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Desert View Counseling and Consulting, Inc. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date:** _____.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X

 Signature of Patient / Parent / Guardian or Authorized Representative
 (Guardian or Authorized Representative must attach documentation of such status.)

 Date

 Printed name of Authorized Representative

 Relationship / Capacity to patient

 Address and telephone number of authorized representative
 DVCC Forms ROI 09242018