DESERT VIEW
COUNSELING & CONSULTING

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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.**
13460 N 94th Dr, Ste. J2
Peoria, AZ 85381

☐ **OR;** ______________________________
____
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The purpose of disclosure is:	**Dates and Type of information to disclose:**
☐ Collaboration of Treatment Care	☐ All Dates of medical records
☐ Change of Insurance or Provider	☐ Dates Other; TO______________ FROM______________
☐ Referral	☐ Specific Information Requested:____________________
☐ Other______________________________	

Information Released (check one of the following): ☐ Verbal Only ☐ Written Only ☐ 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:	**DVCC Office Use Only:**
☐ Please mail records to address provided for recipient	DVCC personnel signature:________________________
☐ Please have records available for pickup at front office	Date Records Provided:________________

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