RELEASE OF INFORMATION

This form is to be used if any person or agency is to obtain your information.

PLEASE PRINT

Name: ____

Date of Birth: ____

Phone Number: ____

I, undersigned, consent to the release of medical records and/ or diagnosis.

TO/ FROM: Name of Person or Agency: ____

Telephone Number: ____

Fax Number: ____

FROM/ TO: Marilyn Levy, Telephone 520.721.8434, Fax 520.298.7075

You must initial each section.

The information I wish to release is:

- Pertinent Information (*initial here*) ___________

The purpose for the disclosure:

- Medical (*initial here*) ___________
- Former Counselors (*initial here*) ___________
- Personal (*initial here*) ___________
- Legal (*initial here*) ___________
- Other: ____ (*initial here*) ___________

Method of Disclosure:

- Telephone (and, or) written documentation (*initial here*) ___________

Record requests that extend beyond pertinent information for continued care may incur cost for handling to cover my costs.

Important, please check & initial each instruction for items 1, 2, 3.

1. Drug and/ or alcohol abuse:
   - May be released (*initial here*) ___________
   - May not be released (*initial here*) __________
2. Mental Health:
   - May be released (*initial here*) __________
   - May not be released (*initial here*) __________
3. Addictions:
   - May be released (*initial here*) __________
   - May not be released (*initial here*) __________

AT LEAST ONE OF THE ABOVE CATEGORIES MUST BE RELEASED FOR BILLING TO OCCUR.

This authorization is valid for one year from the date of signing. I may revoke this authorization at any time with written notice. I may not revoke the authorization retroactively for information that has already been sent/ communicated. In furtherance of this authorization, I hereby waive all provisions of law and privilege relating to the disclosures hereby authorized. With respect to drug and alcohol abuse

treatment information, the recipient of this information understands that it is prohibited from making any further discloser of this information unless disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

Signature of Client/ Participant:____Date_______________

Relationship of Client/ Participant:____Date_______________

Power of Attorney or Authorized Signature:_____________________________________Date_______________