DESERT HORIZON INTEGRATIVE MEDICINE
BEHAVIORAL HEALTH CLINIC
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

840 E. McKellips Rd. Suite 110, Mesa, AZ 85203
Phone: 602-470-5520 Fax: 480-649-0783

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____
Street Apt # City State Zip

SEND RECORDS TO___ FROM___ (please choose one or both)

Name of Person and/or Facility: _____

Address: _____
Street Suite # City State Zip

Phone Number :(_____)_____-_____ Fax Number:(_____)_____-_____

Specific description of the information to be disclosed:

____Full Medical Record
____Demographics ____Med Consent ____Other:_____
____Discharge Summary ____Lab Report _____
____MD Evaluation ____LCSW Evaluation
____MD Progress Notes ____LCSW Progress Notes
____MD Treatment Plan ____LCSW Treatment Plan

Specific description of the purpose of the disclosure:

____Continued patient care ____Other (specify):_____
____Disclosure at patient request _____

I authorize the provider to use or disclose information related to: (must be initialed)

____Behavioral Health care/Psychiatric Care
____Insurance Coverage (COB)
____I consent to the release of information created within 12 months before/after the date this authorization was signed

I understand that by choosing "Full Medical Record", records that are released or obtained may include up to, but not limited to, psychological, psychiatric, or other mental impairments or treatment, **including psychotherapy notes**, drug abuse, alcoholism, or other substance abuse, records which may indicate the presence of communicable or noncommunicable diseases, and/or tests for, or record of, HIV/AIDS, and gene-related impairments, including genetic testing results. I understand that the Clinic will not condition treatment on my signing this authorization. The Clinic will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I understand that I may revoke this authorization at any time, unless the disclosing party has already relied on my authorization to disclose health information. To revoke my authorization, I must submit a written request to Desert Horizon Psychiatric Services. Unless I revoke this authorization earlier, it will expire one year from the date of signature. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person/organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of patient Date

If you are not the patient, but are signing on behalf of the patient, please complete the following:

_____ _____
Printed name Relationship to patient (**Legal guardian ONLY**)

_____ _____
Signature Date