CONSENT FOR RELEASE OF INFORMATION

3610 North 44th Street Suite 140
Phoenix, Arizona 85018
(602) 218-6901

____ ____________ __________
(CLIENT) (DOB) (SSN)

I hereby authorize ____

to exchange the following information (circle one): *Assessment/Evaluation / Diagnosis / Prognosis Triage / Discharge Summary / Psychosocial History / Treatment Plan(s) / Progress Notes / Other:*

____

With the following person(s) or organization (including contact information)

Name____
Address____
City_____________________________________ State___________ Zip__________
Phone_______________________________ Fax_______________________________

The purpose of this exchange or disclosure of information: ___________________________

I understand that I may revoke this release at any time, except to the extent that the practice has taken action in reliance of the consent. Such revocation must be in writing and submitted in writing or e-mail. The consent is valid until revoked; otherwise it will expire on the following date or event__________________________ (unless otherwise noted 60 days from issue date). Please be advised this authorization does not protect the information from being disclosed by the recipient.

Date of information issue__________________________

____ ___________
Signature of Client Date

____ ___________
Signature of Parent/Guardian Date

____ ___________
Therapist Date