Perspective Counseling & Consulting, PLLC
18789 N Reems Road Suite 260
Surprise AZ 85374

Authorization to Disclose Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

I voluntarily authorize Perspective Counseling & Consulting, PLLC to exchange my PHI with:
(One person/Organization per form)
Name: _____ Relationship to Patient: _____
Address: _____
City/State/ZIP: _____
Phone Number: _____ Fax Number: _____

- *Please allow 5-7 business days for processing*

☐ **Mailed** ☐ **I will pick-up** ☐ **Exchange verbal information**

The purpose or need for this disclosure is

☐ Academic/School ☐ Armed Forces/Military ☐ Continuing Care ☐ Employment
☐ Placement/Aftercare ☐ Legal ☐ Personal Use ☐ Other:

The information to be disclosed: check box(es)

☐ Discharge Paperwork ☐ Initial Assessments ☐ History & Physical Exam Reports ☐ Psychiatric Evaluation
☐ Medication Reconciliation ☐ Lab Reports ☐ Billing Statements ☐ Other
☐ Progress Notes ☐ Entire SDI Assessment ☐ Entire PTSI Assessment ☐ Psychological Testing (full report)

I understand that the information to be disclosed may include information about medical, psychiatric, drug/alcohol, mental health, social and/or communicable diseases, including HIV/AIDS. I request the following limitations

DO NOT DISCLOSE:

☐ Alcohol/Drug Treatment/Referral
☐ Sexually Transmitted Disease(s)
☐ HIV/AIDS – related treatments

_____ _____ _____
Signature Time Date

I understand that the I may revoke this authorization at any time, by submitting in writing to Perspective Counseling & Consulting, PLLC attn: Medical Records, except to the extent that actions has been taken. This Authorization shall remain in effect for one year from the signature date unless further limitation is set here by the patient or legal representative:

_____
(Specify New Date)

Your rights regarding release of protected health information (PHI):

- I understand that I may refuse to sign this authorization. My signature is voluntary and treatment or eligibility for benefits is not conditioned upon the execution of this authorization.
- I understand that matters discussed on this form and that I can receive a copy of it. I release the provider and company of liability for the disclosure of my information pursuant to this request.
- My records are protected under federal regulations governing Confidentiality which prohibit further disclosure without written consent unless provided by law or regulation.
- If not subject to federal, state, or HIPAA confidentiality regulations, I am aware that the recipient may re-disclose my PHI without permission.

_____ _____ _____
Patient/Responsible Party Signature Time Date

_____ _____ _____
Perspective Counseling & Consulting, PLLC/Stacey Baughman Time Date

staceybaughmanmapc.com
Phone: 623-910-3371 Fax: 623-249-5141

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