young mind center

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

## PURPOSE OF THIS RELEASE

The purpose of this release is to allow for the collaboration of care of the client.

## NAME OF PERSON WHOSE INFORMATION IS BEING RELEASED

Name: _____ Date of Birth: _____

PRINT NAME OF CLIENT

Parent/Guardian: _____ Primary Phone: _____

PRINT NAME OF INDIVIDUAL PROVIDING AUTHORIZATION

Address: _____

NUMBER / STREET / CITY / STATE / ZIP CODE

**The undersigned hereby authorizes you or any team member or employee of your office who has provided treatment to engage in oral discussion with and/or to release complete and legible copies of any and all written information concerning my physical and/or mental health condition, care, and treatment and disclose and deliver to:**

To: _____

PROFESSIONAL'S NAME / TITLE / ORGANIZATION

Address: _____

NUMBER / STREET / SUITE / CITY / STATE / ZIP CODE

Phone: _____ Fax: _____

## INFORMATION TO BE RELEASED

This authorization shall provide for the release of any and all of my records as defined by A.R.S. § 12-2291, et seq. and includes but is not limited to:

- Session Notes
- Discharge Summaries
- Intake & Progress Reports
- Program Data
- Test Protocols
- Assessment Reports
- Billing Statements
- Photographs, videotapes, digital, other images

## LIMITATIONS

This authorization also specifically authorizes the release of information pertaining to mental health diagnosis and/or treatment (A.R.S. § 36-509).

## REDISCLOSURE

I understand that the Recipient, WITHOUT FURTHER AUTHORIZATION, may redisclose said information and the information may no longer be protected by the Medical Privacy Regulations promulgated under the Health Insurance Portability and Accountability Act (45 CFR §164.508).

## YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

- Right to Refuse to Sign this Authorization – I understand that I am under no obligation to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits.
- Right to Withdraw this Authorization – I understand that I may revoke this Authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper.

## EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires:

- ☐ One (1) year from the date set forth below
- ☐ On _____ (date)

A photocopy, or exact reproduction of this signed Authorization shall have the same force and effect as this original.

## I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

PARENT/GUARDIAN SIGNATURE DATE

YMC REPRESENTATIVE SIGNATURE DATE